Supreme Court, U. S.
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MICHAEL RODAK, JR., CLERK

VOLUME I—Pages 1a-434a
APPENDIX

In the Supreme Court of the United States

October Term, 1978
No. 77-1715

SECRETARY OF PUBLIC WELFARE, Commonwealth of Pennsylvania, ALDO COLAUTTI; JOHN FONG, Director of Haverford State Hospital; NICHOLAS D'ALUISIO, Director of Polk State School and Hospital; C. DUANE YOUNGBERG, Director of Pennhurst State School and Hospital, sued as representative of all others similarly situated,

Appellants

v.

INSTITUTIONALIZED JUVENILES in Pennsylvania Institutions for the mentally ill and mentally retarded, namely, KEVIN S.; RICHARD S.; JAMES PAUL M.; EDWARD B.; RAYMOND C.; WILLIAM B.; FRANCIS B.; MARIA L.; THOMAS W.; NANCY LOUISE D.; GINA S.; and GEORGE S., by their next friend and guardian ad litem, David Ferleger, individually and on behalf of all others similarly situated,

Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

APPEAL DOCKETED MAY 31, 1978
JURISDICTION NOTED JUNE 19, 1978

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley; Steve Gentile; Lesile Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,
Plaintiffs

v.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
Defendants

RELEVANT DOCKET ENTRIES

1972

Nov. 16, Complaint filed.

Nov. 16, Plaintiffs' Memorandum of Law in support of Motion for Class Action and Convening of a Three-Judge Court filed.

Dec. [Illegible,] Defendants' motion to dismiss filed.

1973

Jan. 2, Plaintiffs' first set of interrogatories to Defendants filed.

March 13, Plaintiffs' Motion for class action filed.

June 8, Transcript of 5/10/73 filed.

Aug. 2, Defendants' Memoranda of Law in Support of Defendants' Motion To Dismiss and Defendants' Motion To Oppose Plaintiffs' Motion for a Class Action filed.

Oct. 4, Youth Law Center of San Francisco, California's request for leave to file brief amicus curiae and brief amicus curiae in support of plaintiffs on behalf of Youth Law Center filed.

Dec. 20, Second set of interrogatories to defendants filed.

1974

Jan. 25, Defendants' answers to second set of interrogatories filed.

April 2, ORDER [dated 4-1-74] that argument shall take place before a three-judge Court on 4-16-74 at 10:00 a.m. re: plaintiffs' motion for a class action determination and on defendants' motion to dismiss; briefs of the moving party shall be filed within 8 days from date of this Order, and reply briefs 5 days thereafter, etc. filed. 4-3-74 Entered and copies mailed.

April 16, Argued sur defendants' motions to dismiss, and for class action; Court stated that case may proceed as a single class action. [3-Judge]

April 19, ORDER that hearing and argument shall take place before the three-judge court at such time and place as the court shall designate following the filing of the final pre-hearing Order, by 5-1-74 for plaintiffs' final proposed order, and the holding of the final pre-hearing conference, scheduled for 5-28-74 at 11:00 a.m. in Room 3006, etc. filed. 4-22-74 Entered and copies mailed.

April 29, ORDER that Haverford State Hospital is dropped as a party defendant, and that complaint shall stand amended by said elimination; that this action shall be maintained as a class action under Rule 23 (b) (1) and (2) of FRCP on behalf of the class comprised of all persons 18 years of age or younger who have been, are or may be admitted to mental health facilities in Pa. pursuant to 50 P.S. §§4402 and 4403, etc.; that David Ferleger, Esq. is appointed guardian ad litem for the plaintiffs and their class pursuant to FRCP Rule 17 (c), etc. filed. 4-30-74 Entered and copies mailed.

April 30, ORDER that the Court Order of 4-19-74 [Paper #47] is amended filed. 5-1-74 Entered and copies mailed.

June 6, Answer filed.

July 29, Final Pre-Hearing Order, certificate of service filed.

July 30, Transcript of 4-16-74 re: argument on plaintiffs' motion for a class action determination and on defendants' motion to dismiss filed.

Aug. 21, ORDER granting petition of American Civil Liberties Foundation permitting same to participate

as *amicus curiae* in this cause filed. 8-23-74 Entered and copies mailed.

Aug. 21, ORDER that final hearing and argument shall take place on 9-9-74 at 10:00 a.m., and on 9-11-74 from 9:30 a.m.-1:00 p.m.; that pre-trial briefs are not required, but may be submitted by 9-3-74; that final pre-hearing Order is fully approved, etc. filed. 8-23-74 Entered and copies mailed.

Aug. 23, ORDER [dated 8-22-74] that Pennsylvania Association for Retarded Citizens [PARC], Inc. and National Center for Law and the Handicapped, Inc. are granted leave to participate as *amici curiae* herein filed. 8-26-74 Entered and copies mailed.

Sept. 3, Defendants' Brief, with exhibits in support thereof filed.

Sept. 6, Brief of Amici Curiae, Penna. Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. filed.

Sept. 16, Copy of Brief of Amici Curiae, Penna. Association for Retarded Citizens, Inc. and National Center for Law and the Handicapped, Inc. filed.

Sept. 16, Brief of American Civil Liberties Foundation of Pennsylvania, Inc., Amicus Curiae filed.

Sept. 30, Deposition of Dr. Joel S. Feiner, M.D. of 8-21-74 filed.

Oct. 2, Plaintiffs' Trial Brief, with certificate of service filed.

Oct. 7, Brief of *Amicus Curiae* United States of America, with certificate of service filed.

Oct. 7, Transcript of testimony of Evidentiary hearing of 9-9-74 filed.

Oct. 7, Transcript of testimony of Evidentiary hearing of 9-11-74 filed.

Oct. 7, Deposition of Dr. Barbara Armstrong of 3-2-73 filed. [Exhibit P-7]

Oct. 8, Order that Plaintiffs' proposed Findings of Fact and Conclusions of Law be filed on 10-21-74; Defendants' reply be filed within 10 days of receipt of plaintiffs' Proposed Findings of Fact and Conclusions of Law filed. 10-9-74 entered and copies mailed.

Oct. 18, Plaintiffs' proposed findings of fact and conclusions of law, certificate of service filed.

Oct. 30, Transcript of testimony of Evidentiary Hearing of 10-7-74, Third Day filed.

Nov. 1, Defendants' proposed findings of fact and conclusions of law, certificate of service filed.

Nov. 8, ARGUED SUR: Final merits of the case . . . C.A.V.

Nov. 8, ORDER that plaintiffs' request for admission of Exhibits 2 and 3 is DENIED filed. 11-11-74 Entered and copies mailed.

1975

June 25, Order denying plaintiffs' motion for temporary restraining order, etc. filed. 6/26/75 entered and copies mailed.

July 24, *Opinion,* Huyett, J., Gibbons, J. and Broderick, J. finding §§402 and 403 unconstitutional, etc. filed.

July 24, Order that judgment is entered in favor of plaintiffs and against defendants: Counsel for the parties shall confer and submit an appropriate form order consistent with Opinion within 20 days filed. 7/25/75 entered and copies mailed.

Aug. 7, DISSENTING OPINION, Broderick, J., to the opinion of the court of 7/24/75 filed. 8/7/75 entered and copies mailed.

Aug. 22, Defendants' notice of appeal filed. (Certificate of service) (75-2121)

Oct. 17, Defendants' exceptions to proposed order, etc. and certificate of service filed.

Oct. 31, Certified copy of Order from USCA wherein appellants' motion for leave to stay all proceedings until 30 days after the Supreme Court of the U. S. acts in this matter is GRANTED; motion by plaintiffs-appellees to dismiss appeal with memorandum of law in support of motion to dismiss appeal, etc. is DENIED without prejudice, etc. filed.

Nov. 17, ORDER that this action is properly maintained as a class action and that certain sections of the Pennsylvania Mental Health and Mental Retardation Act are declared invalid, etc. filed. 11-18-75 entered and copies mailed.

Nov. 25, Defendants' motion for a stay and certificate of service filed.

Nov. 26, Defendants' notice of appeal to the Supreme Court (Final Order) and certificate of service filed. (75-1064)

Dec. 1, ORDER that defendants' motion to stay is DENIED filed. 12-2-75 entered and copies mailed.

1976

Feb. 4, Certified copy received from the Supreme Court of the U. S. re file of petition for a writ of certiorari on 1-27-76 as #75-1064, etc. filed.

COMPLAINT—NOVEMBER 16, 1972

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Haverford State Hospital; Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

COMPLAINT—CLASS ACTION

I.

PRELIMINARY STATEMENT

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1. Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief,

and damages, for violations of their civil rights resulting from the operation of certain parts of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which permit the involuntary commitment of persons eighteen years of age or under to mental health facilities on a different basis than other persons and without notice, hearing, right to counsel and other procedural safeguards. The convening of a three judge court is also sought. The statutes are challenged on the grounds that they conflict with the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

II.

JURISDICTION

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2. Jurisdiction is conferred upon this court by 28 U.S.C. § 1331 which provides for original federal question jurisdiction. The amount in controversy, exclusive of interest and costs, is greater than $10,000.

3. Jurisdiction is conferred upon this court by 28 U.S.C. § 1343(3) which provides for original jurisdiction in all suits authorized by 42 U.S.C. § 1983 to redress the deprivation under color of state law of any right, privilege or immunity secured by the Constitution of the United States and by federal law. Defendants here act under color of law.

4. Plaintiffs' action for declaratory and injunctive relief, and for damages, is authorized by:

a. 28 U.S.C. 2201, 2202, 2281 and 2284, and by Rules 57 and 65 of the Federal Rules of Civil Pro-

cedure, which relate to declaratory judgments, injunctions and three judge courts.

b. 42 U.S.C. §§ 1983 and 1988, which relate to civil rights actions.

III.

THREE-JUDGE COURT

---

5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since Plaintiffs seek an injunction to restrain Defendants, a state institution and state officers, from the enforcement, execution and operation of portions of state statutes (50 P.S. §§ 4402(a)(1), 4402(a)(2), 4402(c), 4403(a)(1), 4403(a)(2) and 4403(c)) of state-wide applicability on the ground that said statutes are contrary to the United States Constitution.

IV.

CLASS ACTION

---

6. The named Plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of all others similarly situated.

7. The members of the class of Plaintiffs similarly situated are all persons under eighteen years of age who have been, are, or may be admitted or committed to Haverford State Hospital and all other state mental health facilities under the challenged provisions of the state statute.

8. The requirements of Rule 23 are met in that: the class is so numerous that joinder of all members is impractical (and the total membership of the class is indeterminate); there are questions of law and fact common to the class; the claims of the representative parties are typical of the claims of the class; the representative parties will fairly and adequately protect the interests of the class; and the parties opposing the class have acted on grounds generally applicable to the class, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

9. Defendant Jack B. Kremens, Hospital Director of Defendant Haverford State Hospital, is sued as representative of the directors of all mental health facilities in Pennsylvania, all of which are under the authority and supersion and regulation of Defendants Wohlgemuth and Beach. All the allegations in Paragraph 8 above (with the exception of the last clause) are applicable here and are incorporated by reference.

10. The questions of law and fact involved are:

a. Are the representative parties, and their class, admitted or committed involuntarily to Defendant Haverford State Hospital and other mental health facilities pursuant to the challenged statutory provisions?

b. Do Defendants operate, execute and enforce the challenged statutes?

c. Are the challenged statutes contrary to the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution?

V.

PLAINTIFFS

11. Plaintiff Kevin Bartley is a citizen of Pennsylvania, age 16, having been born November 4, 1956.

12. Plaintiff Steve Gentile is a citizen of Pennsylvania, age 18, having been born March 20, 1954.

13. Plaintiff Leslie Levine is a citizen of Pennsylvania, age 15, having been born October 8, 1957.

14. Plaintiff Vicki Mathews is a citizen of Pennsylvania, age 15, having been born September 10, 1957.

15. Plaintiff Mark Weand is a citizen of Pennsylvania, age 15, having been born June 13, 1957.

16. All named Plaintiffs are being held at Defendant Haverford State Hospital against their will having been admitted or committed by Defendants or under their direction pursuant to the challenged sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Such admissions and commitments were accomplished without notice, hearing, right to counsel or order of court.

VI.

DEFENDANTS

17. Defendant Haverford State Hospital is a mental health "facility" under Section 102 of the Pennsylvania Mental Health and Mental Retardation Act of 1966.

It receives admissions and commitments of persons, including Plaintiffs and their class, under said act.

18. Defendant Jack B. Kremens is Hospital Director of Defendant Haverford State Hospital and is charged with supervision and administration of the facility. See Sections 102 and 203 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (hereafter the "Act"). It is to Kremens or his delegate that applications for admission, commitment and release must be made. See Sections 402 (b), 403 (b) and 403 (c) of the Act.

19. Defendant Helene Wohlgemuth is the Secretary of Public Welfare of the Commonwealth of Pennsylvania which department has the power and duty to enforce the Act and all regulations necessary and appropriate to the proper accomplishment of the Act and to operate and assign functions to all state facilities. See Sections 201 (2) and 202 (a) of the Act.

20. Defendant William B. Beach, Jr. is the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania. He has general authority to supervise and regulate mental health facilities within Pennsylvania.

VII.

FACTUAL ALLEGATIONS

Kevin Bartley

21. Plaintiff Kevin Bartley was committed to Haverford State Hospital on November 30, 1971 under Section 403 (a) (2) of the Act.

22. He was committed by his mother although he did not wish to enter the hospital then and does not wish to remain now. Kevin Bartley is critical of many of what he believes are the hospital's shortcomings: e.g., arbitrary regulations, the staff's playing favorites with patients, unnecessary punishments for minor rule infractions, and transfer to locked wards as punishment for mere allegations of wrongdoing, without hearing or proof.

23. Bartley believes that nothing worthwhile is occurring to him inside the hospital and that his time is mostly being wasted. This is true. When he obtains release, he plans to go to school and learn a usable trade.

Steve Gentile

24. Plaintiff Steve Gentile was committed to Haverford State Hospital on August 24, 1971 by his father under Section 403 (a) (2) of the Act.

25. Gentile entered the hospital involuntarily, is being detained there involuntarily and wishes to leave but is restrained from doing so by Defendants and the operation of the challenged portions of the Act.

Leslie Levine

26. Plaintiff Leslie Levine's mother committed her to Haverford State Hospital on October 11, 1972 under Section 403 (a) (2) of the Act.

27. Levine does not wish to remain at the hospital but is restrained from leaving by Defendants and by the operation of the challenged portions of the Act.

28. Levine was committed to the hospital because she does not get along with her mother and sister. Her parents are divorced; her father is remarried and living in Florida. Leslie Levine would like to be with her father; they get along well and, every time she spends some time with him, her behavior is excellent. However, because she is with her mother and sister and does not get along with them, Levine is an involuntary mental hospital patient.

Vicki Mathews

29. Plaintiff Vicki Mathews was committed to Haverford State Hospital on August 9, 1972 by her parents under Section 403 (a) (2) of the Act.

30. She entered the hospital involuntarily.

31. Mathews does not get along well with her parents and has in the past run away from home. If she were considered a "delinquent," and dealt with through the juvenile court process, she could not be institutionalized against her will except after a full hearing, upon order of a court. In fact, as the mental health commitment laws permit, her parents had the choice of avoiding the due process protections afforded juveniles in other contexts and of dealing with her in their own way, thus depriving Mathews of any hearing and committing her to a mental hospital.

32. Because her parents had the financial means, on information and belief, they applied for her discharge from the hospital under Section 403 (c) so that she could be shipped, against her will, to a boarding school in Texas.

Mark Weand

33. Plaintiff Mark Weand was admitted to Haverford State Hospital on June 23, 1972 by his mother under Section 402 (a) (2) of the Act.

34. After another hospital would not admit him because of his age, Weand first entered Haverford for medical reasons because of excess use of drugs. Once at the hospital, his mother was convinced by agents and employees of Defendants to have Weand admitted for psychiatric reasons. Weand did not wish to become a mental patient and repeatedly has informed Defendants' agents and employees of his desire to leave. They have not permitted him to do so.

35. At the hospital, Weand has not been involved with any therapeutic drug programs because he has not been addicted to any drugs.

36. His mother is concerned about him but will not apply for his release except upon the approval of the hospital physicians, employees and agents of Defendants. If Weand were a voluntary patient under Section 402 of the Act and were over eighteen, he would be permitted to leave the hospital "at any time" regardless of the physicians' approval or opinion.

37. The major reason Weand has been hospitalized for the past five months is that the hospital's agents and employees have considered his attitude hostile and aggressive. The basis for this "hostile" and "aggressive" attitude is Weand's belief that he doesn't belong in the mental hospital and Weand's questioning and criticism of the hospital regimen and his treatment there.

The Statutory Scheme

38. Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4402) provides as follows: (Those parts which are challenged as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 402. Voluntary Admission; Application, Examination and Acceptance; Duration of Admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) *Except where application for admission has been made under the provisions of Section 402 (a) (2) and the person admitted is still eighteen years of age or younger*, any person voluntarily admitted shall be free to withdraw at any time. *Where application has been made under the provisions of Section 402 (a) (2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.*

(d) Omitted here.

39. Section 403 of the Act (50 P.S. § 4403) provides as follows. (Those parts which are challenged as unconstitutional by this Complaint are emphasized by underlining [italics])

Section 403. Voluntary Commitment; Application, Examination and Acceptance; Duration of Commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, *or after the applicant or his successor has given notice of intention or desire to remove the detained person.*

(d) Omitted here.

40. The only other provisions for civil commitment to a mental health facility provided by the Act are:

a. Section 404 which permitted commitment of persons upon application of third parties (including parents, guardians, individuals standing in loco parentis, etc.) upon application with certificates of two physicians. Because of its denial of Constitutional Due Process rights, this section has been declared unconstitutional. See Section 404 and *Dixon v. Attorney General of the Commonwealth of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971).

b. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than ten days.

c. Section 406 permits involuntary commitment of persons, regardless of age, upon petition to the state court of common pleas, and after hearing and examination. The respondent to such petition has the right to notice of the hearing, the right to counsel and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

VIII.

FIRST CAUSE OF ACTION

For a First Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference, and further allege:

41. Voluntary patients over eighteen years of age enter facilities under the Act on their own application and

volition under Section 402 or 403 and may leave and discharge themselves either at any time (Section 402) or upon proper written notice (Section 403). Plaintiffs and their class are denied such entrance and separation from the facility by the challenged portions of these sections of the Act.

42. The statute thus creates two classes of potential and actual "voluntary" admittees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

43. A person over eighteen years of age who does not wish to enter a facility may be placed there involuntarily only upon the order of a court pursuant to the procedures, including a petition, notice and hearing, mandated by Section 406 of the Act. A person under eighteen years of age who does not wish to enter a facility may be placed there involuntarily simply upon the application of a parent, guardian or individual standing in loco parentis; no notice or petition is required nor is any sort of hearing or court order provided for.

44. The statute thus creates two classes of potential and actual involuntary admittees and committees, distinguishable only on the basis of age. There is no adequate state justification for this arbitrary classification.

45. The challenged portions of the Act and Defendants' actions in operating, enforcing and executing the same, deny Plaintiffs and their class the equal protection of the laws in violation of the Fourteenth Amendment to the United States Constitution.

IX.

SECOND CAUSE OF ACTION

For a Second Cause of Action, Plaintiffs reallege Paragraphs 1 through 40 above, which are incorporated herein by reference and further allege:

46. By operation of the challenged portions of the Act, Plaintiffs and their class are detained and incarcerated involuntarily in mental hospitals and other facilities without:

a. the right to notice;

b. the right to a hearing;

c. the right to counsel and, if indigent, appointment of counsel;

d. the right to present evidence and testimony on their own behalf;

e. the right to subpoena witnesses and documents;

f. the right to confront and cross-examine witnesses against them and those who wish them to enter a facility;

g. the right to independent expert examination and assistance;

h. the right to be involuntarily detained only upon decision of a disinterested and impartial decision-maker;

i. the right to be involuntarily detained only upon a decision that they are in need of care, treatment or observation, such decision being based on clear and convincing evidence;

j. the right to appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

k. other procedural safeguards.

47. By operation of the challenged portions of the Act, and by Defendants' actions in operating, enforcing and executing the same, Plaintiffs and their class are deprived of their life, liberty and property without due process of law in violation of the Fourteenth Amendment to the United States Constitution.

X.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray, on behalf of themselves and all others similarly situated, that this Honorable Court:

1. Assume jurisdiction of this cause, convene a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 to determine this controversy, and set this case promptly for an expedited hearing;

2. Determine by Order, pursuant to Rule 23(c) (1) of the Federal Rules of Civil Procedure, that this action be maintained as a class action;

3. Enter a final judgment, pursuant to 28 U.S.C. §§ 2201 and 2202 and Rule 57 of the Federal Rules of Civil Procedure declaring that the challenged portions of the Pennsylvania Mental Health and Mental Retardation Act of 1966, that is 50 P.S. §§ 4402(a) (1), 4402(a) (2),

4402(c), 4403(a) (1), 4403(a) (2), and 4403 (c) (see paragraphs 38 and 39 above), are invalid, void and of no effect on the grounds that they violate the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution;

4. Enter preliminary and permanent injunctions enjoining Defendants from enforcing and executing such statutory provisions;

5. Award damages to each of the named Plaintiffs in the amount of $15,000 each for unconstitutional deprivation of their rights;

6. Allow Plaintiffs their costs herein and reasonable attorney's fees;

7. Grant such additional and alternative relief as may be deemed by this Court appropriate, just, proper and equitable.

Respectfully submitted,

(s) David Ferleger
David Ferleger
Attorney and Next Friend for Plaintiffs
Mental Patient Civil Liberties Project
121 South 18th Street
Philadelphia, Pa. 19103
(215) 561-4715

On the Brief:

Ronald Soskin
Stan Abramson

Dated November 16, 1972

MOTION TO DISMISS

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

MOTION TO DISMISS

Defendants move that this Honorable Court dismiss the above captioned action on the basis that Plaintiffs have failed to plead an action upon which relief may be granted.

Marx S. Leopold
Assistant Attorney General

December 12, 1972

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

FIRST SET OF INTERROGATORIES TO DEFENDANTS

Definitions

As used in the interrogatories below, the following words shall be taken to have the following meanings:

a. "Juvenile (s)"—Persons eighteen years of age or younger.

b. "Facility (ies)"—"Any mental health establishment, hospital, clinic, institution, center, day care center or other organizational unit, or part thereof, which is devoted primarily to the diagnosis, treatment, care, rehabilitation or detention of mentally disabled persons." (As defined in the Mental Health and Mental Retardation Act of 1966).

c. "Act"—The Pennsylvania Mental Health and Mental Retardation Act of 1966.

d. "Director (s)"—"The administrative head of a facility and includes superintendents." (As defined in the Act).

e. "Department"—The Department of Public Welfare.

f. "Adult (s)"—Persons over eighteen years of age.

g. "Civil Commitment"—Commitment to a facility under Section 406 of the Act.

h. "Voluntary Admission"—Admission or commitment to a facility under Section 402 or Section 403 of the Act.

i. "State"—Pennsylvania, often with reference to the state government.

Interrogatories

1. Name all the state facilities, that is, those owned and operated by the state. Also, their addresses.

2. What are the names of all the facilities in Pennsylvania which are privately owned, regulated by the state and the Department, and which admit or commit any persons under the Act? Also, their addresses?

3. What are the policies of the Department with regard to criteria for admission or commitment of juveniles to facilities, that is, what criteria are used?

4. What are the policies of the Department with regard to criteria for admission and commitment of adults to facilities, that is, what criteria are used?

5. What are the policies of Directors with regard to acting upon applications for voluntary admissions of juveniles to facilities, that is, what criteria are used?

6. What are the policies of Directors with regard to acting upon applications for voluntary admissions of adults to facilities, that is, what criteria are used?

7. Identify and describe the nature, custody and location of all memoranda, directives, orders, policies, regulations and other or similar documents issued by the Department or other state authorities or known to Defendants which pertain to the voluntary admission or civil commitment of juveniles to facilities.

8. Identify and describe the nature, custody and location of all memoranda, directives, orders, policies, regulations and other or similar documents issued by the Department or other state authorities or known to Defendants which pertain to voluntary admission or civil commitment of adults to facilities.

9. Name all juveniles presently in all facilities as voluntary admissions and provide the name of the facility each is in.

10. Name all juveniles presently in all facilities as civil commitments and provide the name of the facility each is in.

11. For each juvenile in a facility as a voluntary admission, what is or are the major behaviors or activities upon which such admission was based?

12. For each juvenile in a facility as a civil commitment, what is or are the major behaviors or activities upon which such commitment was based?

13. For each juvenile in a facility as a voluntary admission, what is the name and address of the applicant for admission and identify the relationship of the applicant to the juvenile (e.g., parent, guardian or person *in loco parentis*) ?

14. For each juvenile in a facility as a result of a civil commitment, what is the name and address of the

Petitioner and identify the relationship of the Petitioner to the juvenile?

(s) David Ferleger
David Ferleger
Mental Patient Civil Liberties Project
121 S. 18th Street
Philadelphia, Pa. 19103
Attorney for Plaintiffs

December 22, 1972

Please answer, in accordance with Rule 33, within thirty days.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

MOTION FOR CLASS ACTION

Plaintiffs, by their attorney and next friend, David Ferleger, Esquire, respectfully move this Honorable Court to order that this action be maintained as a class action.

Rule 23(c) provides:

> As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be so maintained. An order under this subdivision may be conditional, and may be altered or amended before the decision on the merits.

In their *Memorandum of Law in Support of Motion for Class Action and Three-Judge Court,* filed with the Complaint, Plaintiffs detailed the argument on which they here rely at pages 1 through 3 of that memorandum. No

memorandum or motion has been filed in opposition by Defendants, except a motion to dismiss under Rule 12 (b) (6).

Respectfully submitted,
(s) David Ferleger
David Ferleger, Esquire
Mental Patient Civil Liberties Project
121 South 18th Street
Philadelphia, Pa. 19103
Attorney and Next Friend to Plaintiffs

March 13, 1973

[Certificate of Service omitted.]

ORDER

[Caption Omitted]

AND NOW, this 25 day of April, 1973, it is hereby ordered and decreed that:

1. The two affidavits of juveniles at Haverford State Hospital submitted by Plaintiffs on April 12, 1973 to this Court be sealed and impounded until further order of this Court;

2. The parties and their attorneys shall not disclose to others the names of the affiants except with the permission of the Court. The contents, without identifying data, may be disclosed;

3. Defendants, their agents and employees, are enjoined from interfering with the First Amendment rights of affiants and from punishing, disciplining, interrogating or otherwise imposing sanctions on affiants by reason of their affidavits herein.

For the Court:
(s) Thomas A. [Illegible]
J.

[Caption Omitted]

MOTION FOR SEALING OF AFFIDAVITS AND PROTECTION OF AFFIANTS

David Ferleger, attorney for Plaintiffs, respectfully represents that:

1. Attached are two affidavits of juveniles now at Haverford State Hospital pursuant to the challenged portions of the state mental health act. Their parents and various mental health professionals, including the Defendants and their agents, caused their commitment.

2. The affiants would be embarassed and their (and their families') reputation affected adversely by public disclosure of their names and their affidavits.

3. The affiants fear that the Defendants and their employees will take disciplinary or other action against them for their criticisms of their confinement as expressed in these affidavits.

Wherefore, it is respectfully prayed that: 1) these affidavits be sealed and impounded until further order of the Court; 2) the parties and their attorneys be ordered not to disclose the names of the affiants to the public except with the permission of the Court; and 3) the Defendants, their agents and employees be enjoined from interfering with the First Amendment rights of affiants and from punishing, disciplining, interrogating or otherwise imposing sanctions on affiants by reason of their affidavits herein.

Respectfully submitted,
(s) David Ferleger
David Ferleger, Esquire
Mental Patient Civil Liberties Project
121 S. 18th Street
Philadelphia, Pa. 19103

This is to certify that on day of April, 1973, I mailed a copy of the foregoing to Marx Leopold, Esq. and Barry Roth, Esq., Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa.

David Ferleger

[Caption Omitted]

AFFIDAVIT

My name is A . . . M . . . I was transferred to Haverford from the University of Pennsylvania Hospital. My parents brought me here, but I didn't want to come. It was too late, I couldn't do anything about it. I said I didn't want to stay here. The doctor got me to admit that I needed help but I told him that I still didn't want to stay. Like I know some girl that was here a couple of weeks ago, Debbie Geiger, her parents told her they were going to see a doctor—that's how she got here. But if you're under 18, well you know.

When I first got here they pushed me into a room and told me to take off my clothes and put on pajamas. Then they took me up to the fifth floor. I wasn't expecting to be locked up. It really drives you crazy. They didn't explain anything to me—they put you up there and that's it. My mother says if she knew that she wouldn't have put me in here. I was up there 3 or 4 days before I was sent to Building 9.

They threaten you here—that's the really bad part. You do what we say or you go up the hill or something—restrictions. Like me and D . . . D . . .—we'll probably get sent up the hill again cause we didn't go to our half hour of art therapy. D . . . got sent up for five days because he wouldn't take his restrictions. They don't care—they don't care about anything. The evening and late night staff stinks. The only staff that really cares is the day staff.

I got transferred to Building 4 one night. I cut myself on purpose. My hands were bleeding and they said I was going for a tetanus shot. They didn't explain what they were doing or tell you they were taking you up. They should at least have told my parents. I would still be there but my doctor, Dr. Kratsa, got me back the next day. If you get sent up on a Friday and your doctor is only here Tuesday, Wednesday and Thursday, you'll be there till next Tuesday at least. Do you think you can do anything about the restrictions and us getting sent up the hill?

I am presently a patient at Haverford State Hospital. Since a notary public is not available at the hospital and since I am not able to secure release for the purpose of signing before a notary public, I am forced to sign without notarization. I swear that the above statements are true and correct to the best of my knowledge, information and belief and I sign below under pain of perjury.

(s) A . . . M . . .

Signed on this 9th day of April, 1973.

[Caption Omitted]

AFFIDAVIT

My name is D . . . D . . . I am 14 years old and live with my parents at 2624 Sunset Boulevard in Broomall, Pennsylvania.

Before I got here I was on probation for truancy. I broke probation because I was truant again. My parents told me they wanted to have a meeting with me down at Haverford State. My mom said a psychiatrist and a social

worker would be there. This woman at the Media Court House recommended to my parents that they bring me here. They wanted me to come that day but I said no, I wanted to say goodbye to my friends that night. I came the next morning at 7 a.m. I didn't even get to see my probation officer. When I got to the hospital the doctor, Dr. Kratsa, wanted me to go to reform school. My parents kept saying no. They made it sound like if I didn't come here I'd be going to reform school. So I figured it would be a lot better here than reform school. So I said yes. That's how they tricked me.

About the only big complaint I have is the restrictions. That's the only thing that's a matter with this hospital. I was supposed to sit in my alcove for two nights because I didn't do clean-up. I got sent up the hill to the locked building because I wouldn't take my restrictions. I think that's pretty stupid. Why should we be sent up there? We don't belong there with those people. They ought to have a better way of punishing you. I was there for 5 days—I've never been locked up for a length of time like that before. There are people there that bothered me and wanted me to let them do stuff to me, but I don't want to get them in trouble—that's just part of their problem. One guy used to wake me up and pounce on top of me and hit me.

The fourth floor of Building 4 is worse than the fifth floor where I got sent the first time. I had a bad day in Building 9 and I was mixed up and I didn't want to stay there that night, but they wouldn't let me go to Building 4 just for the night. So I broke a window to get sent there. They found phenobarbitol tablets in my room after I broke the window. I got them here at the hospital—a lot of kids in the building did. That's why a lot of us got sent

up here. I had a bowl of grass too that I had from home. My friends used to bring up stuff too. The fourth floor is worse than the fifth. I've been here over a week now. Most of them on this floor want to try stuff with me but I won't let them. One guy gave me all sorts of presents and then he told me what he wanted me to let him do just like the others, but I told him no. I want to get off this floor. I'll never bring any dope in anymore. I like the stuff they're giving me here though—I'm flying. Don't let them change it. I'd rather be on the fifth floor again or in Building 9. I want to be able to go home on the weekends. I'll write a commitment saying I won't do dope anymore. I'd like you to try and help me. I want you to talk to my doctor, Dr. Kratsa, about all of this.

I am presently a patient at Haverford State Hospital. Since a notary public is not available at the hospital and since I am not able to secure release for the purpose of signing before a notary public, I am forced to sign without notarization. I swear that the above statements are true and correct to the best of my knowledge, information and belief and I sign below under pain of perjury.

(s) D . . . D . . .

Signed on this 9th day of April, 1973.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, Mark Weand, minors, through their next friend, individually, and on behalf of all others similarly situated

vs.

Haverford State Hospital, Jack B. Kremens, et al.

Oral examination before trial by Dr. Barbara Armstrong, at the law office of Mental Patient Civil Liberties Project, David Ferleger, Esquire, 121 South 18th Street, Philadelphia, Pennsylvania, on Friday, March 2, 1973, at 10:00 a.m., before Patricia M. Kosmalski, Approved Reporter.

Present:

David Ferleger, Esq., and Stan Abramson, Esq., Counsel for the Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Counsel for the Defendants.

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(2) (It is stipulated and agreed by and between counsel that sealing, filing, and certification of the

examination before trial be waived, and that all objections, except as to the form of the questions, be reserved to the trial of the cause.)

DR. BARBARA ARMSTRONG, Director of Adolescent Services, Haverford State Hospital, Haverford, Pennsylvania, sworn.

MR. FERLEGER: Dr. Armstrong, do you understand the purpose of this deposition?

THE WITNESS: No.

MR. FERLEGER: The purpose of a deposition, under the Federal Rules of Civil Procedure, under the rules of lawsuits conducted, each side is afforded the opportunity for discovery to find out what potential witnesses may have to say, and to record testimony in case it is needed in the future for court. The deposition can be used in court to contradict or impeach what you say. It can be used in court if it happens that at the time of trial or hearing, you happen to (3) be more than a hundred miles away.

For example, you can't come if you should die before the court hearing. This deposition can be used as your testimony in that case, and under other exceptions and circumstances, it can also be used.

Because it can be used in court and because of the seriousness of the discovery process, you were sworn at the time this deposition was taken. So, you are obliged to tell the truth, as this is a serious kind of thing we are about to begin here today.

THE WITNESS: Yes. I understand.

MR. FERLEGER: Have you read the complaint and memorandum in the Bartley suit?

Mr. Roth, I would appreciate it if you don't shake your head and answer for her.

MR. ROTH: I am not answering.

THE WITNESS: I am not sure. I remember I read the deposition, I guess, in this case, of Dr. Kremens.

MR. FERLEGER: Have you read this paper captioned, "Complaint in Class, More Than In Law, of Class Action"?

(4) MR. ROTH: Do you mind showing me copies? Do you want to state your purpose of this deposition—I imagine, your objective, instead of going into needless impressions or embarrassment?

MR. FERLEGER: My objective is to determine what information Dr. Armstrong might have that would lead to discovery of other relevant material in this lawsuit. Since she is the doctor of a number of named plaintiffs and other members of this class action, I want to talk to her about problems involved. I don't know where you got the idea I have the desire to embarrass or press her.

MR. ROTH: I am concerned that this is going to be a fishing deposition, and I am going to make a motion to discontinue the deposition.

MR. FERLEGER: As to what questions I ask, if you want to object, you can object.

MR. ROTH: I am well aware of the rules of federal court.

I want you to know that I will make the appropriate motion now to terminate this deposition.

MR. FERLEGER: Any motion you wish to (5) make is up to you.

MR. ROTH: Let's proceed. Let's get on to the deposition proper.

THE WITNESS: Mr. Ferleger, what is the proper procedure? If you don't mind, may I ask you a question?

MR. FERLEGER: No, I will be glad to answer any questions you have, if I can.

THE WITNESS: Is it necessary that I have read the memorandum, which I did not see? I have no idea of its contents.

MR. FERLEGER: It is necessary. I was going to try to find out as to whether you were familiar—

THE WITNESS: My capacity is, in addition to being an administrator, as well as a director, a director of a specific specialty service named, "Adolescent Services," at Haverford State Hospital. I am not just one of the hospital's doctors involved in certain cases. Therefore, I must represent my staff.

Secondly, I would like to request that any correspondence or memorandums that were sent to or by Dr. Kremens in regard to this suit, I (6) be allowed to see.

MR. FERLEGER: Certainly. I think the appropriate thing for you to do is to ask your counsel to share with you the legal papers that were filed with the court.

MR. ABRAMSON: I want to mention that at any time if you don't understand or realize what it is we are asking you, or you are not quite clear on it, feel free to ask a question. Don't hesitate because you don't understand what you are being asked. Then again, please do not answer any question until you do understand it.

MR. FERLEGER: In reference to what you just said, doctor, we have asked you to come to this deposition, and what you say here the law requires it be your opinion and your feelings, not the feelings of your staff or Dr. Kremens.

If we had wanted the hospital's position—or personnel—at Haverford State Hospital, we would have asked them to send, under federal rules, a representative of the hospital.

We ask you, Dr. Barbara Armstrong, because you took an oath, to say what your answers are (7) to these questions.

THE WITNESS: That I understand, but there is a condition, in that you ask for, also, at least, a licensed representative presently in the hospital. In that regard, I have to convey information I haven't gathered myself.

Direct Examination

BY MR. FERLEGER:

Q. Can you give us your background, education, and professional experience?

MR. ROTH: If we can dispense with that, or do you plan to attack her credibility as a psychiatrist

or as a licensed psychiatrist who practices at Haverford State Hospital? It would save time.

MR. FERLEGER: She might have more qualifications.

MR. ROTH: Can you indicate the purpose of it?

MR. FERLEGER: Her experience and educational background is certainly relevant in court and—

MR. ROTH: The only way it is relevant (8) is if you are going to attack her credibility as a practicing psychiatrist.

MR. FERLEGER: If I want to qualify her as an expert witness, it is relevant.

MR. ROTH: But the question is whether we can agree she is an expert witness. Do you want her to perform as an expert witness?

MR. FERLEGER: This is discovery.

MR. ROTH: You are fishing.

MR. FERLEGER: I am not fishing.

BY MR. FERLEGER:

Q. (Continued) Where did you go to school?

A. To Temple undergraduate school and Hahnemann Medical College, and the University of Pennsylvania Hospital for Psychiatric Residence, with a specialty in psychiatry.

Q. Did you go from the University of Pennsylvania Hospital to Haverford?

A. No, I was at Devereux for a year, and for three years I was chairman of the Department of Psychiatry for

a U.S. Army hospital in Badcreusnach, Germany, and upon returning to the United States, I took a position at Haverford State, with the purpose of setting up and directing an adolescent service.

(9) Q. Did your work involve adults and adolescents?

A. Child guidance clinic and in an adolescent clinic. So my work did involve both adults and children as chairman of that department.

Q. How long have you been at Haverford?

A. Four years.

Q. How long have you been the Director of Adolescent Services?

A. The entire time.

Q. During these past four years, have you had experience with the court commitments of juveniles, as well as voluntary commitments?

A. Yes, I have.

Q. Have you testified in court hearings?

A. Yes.

Q. For juveniles?

A. Yes.

Q. Have you also been involved in procedures for admission of juveniles, pursuant to application by their parents under the Act?

A. Yes.

Q. Can you tell me, please, what the procedure is at Haverford when parents call up or present themselves or their children at the hospital, saying they want the (10) child to be admitted as a voluntary patient?

A. The hospital has no specific admission policy. It follows the Mental Health and Retardation Act of 1966.

You are familiar with the Act?

Q. I didn't mean the criteria. I am just interested in what happens—

MR. ROTH: I object. I think Dr. Armstrong answered that question. You asked her what procedure occurs at Haverford, and she stated it is in compliance with the Mental Health and Retardation Act.

BY MR. FERLEGER:

Q. The Act says the director makes a finding, but Jack Kremens doesn't do that.

MR. ROTH: I object to this questioning. You asked her what the procedure is and she has informed you.

MR. FERLEGER: Your objection is noted. She can now answer.

MR. ABRAMSON: What we are interested in is not what the Act calls for specifically, but how it is applied at the hospital. In other words, if, for instance, a parent or guardian (11) feels that they would like to have their child, or the person who they are responsible for, enter the hospital, what are your actual mechanics: who do they see; what actually goes on or takes place before the child is or is not admitted, in a very practical sense?

MR. ROTH: I appreciate this elaboration, Mr. Abramson.

We are confining this to 402 and 403 of the Act?

MR. ABRAMSON: Yes.

THE WITNESS: Also, persons 18 years of age and under?

MR. ABRAMSON: Yes.

A. Practically speaking, my understanding of the Mental Health and Retardation Act is such that the director may designate a professional on his staff to make an examination. Subsequently, what happens, this prevents a person, the applicant who is either a parent or guardian, from acting in loco parentis.

The child who is 402, is then brought in for examination. On a 402, it is a prescheduled general admission, therefore, they are examined by one of the members of the Adolescent Services, at which time, a (12) determination is made whether the child needs, in fact, care in the hospital, or what facilities. If it is not indicated, the child is not admitted. If it is indicated, a child is admitted and sent to the appropriate facility. As part of our services, if the child needs the services of the Adolescent Services, then he is admitted to the hospital at large. A social worker, in fact, who is designated as part of the Adolescent Services, then contacts the parent for further personal history or further studies.

Q. Is that initial examination by one of your staff?

A. Generally.

Q. Does that take one day or half a day?

MR. ROTH: I object to that question.

BY MR. FERLEGER:

Q. (Continued) How long?

MR. ROTH: I object to that question.

MR. FERLEGER: She can answer now.

MR. ROTH: I am familiar. I want you to know I don't want you jumping at her.

MR. FERLEGER: I want her to realize that Mr. Roth is objecting for the record as permitted, and you are required to answer.

We don't have a Judge here to rule.

(13) MR. ROTH: But you are permitted to elaborate.

BY MR. FERLEGER:

Q. (Continued) The initial examination after the application—the one you referred to usually by a member of your staff—what is the usual length of time for that examination?

A. We should qualify it and say the examination is by a psychiatrist, not any other discipline, and the length of time is variable. It depends on the individual psychiatrist and whether the child is interviewed alone or with a family member present—anywhere from an hour to three quarters of an hour. On occasion, if it is not done by other staff, it may be the same period of time or shorter.

Q. In a court commitment under Section 406 of the Act, as you probably know, the first part of the procedure involves, usually—the person is not then hospitalized—it involves just lay testimony, is that right, somebody presents a petition?

MR. ROTH: I object to that as being argumentative, and calls for a conclusion of law as to what a 406 commitment is.

(14) BY MR. FERLEGER:

Q. (Continued) I will ask it this way.

When a juvenile is committed under court commitment, you testified that those persons are referred to you, haven't you?

A. Yes, I have.

Q. After you testified—in your experience, very often the court commits the juvenile for a period of 10 days for evaluation and observation; isn't that correct?

A. 10, 30, 60, or an indefinite period.

MR. ROTH: I object to your line of questioning, based on—

BY MR. FERLEGER:

Q. What I mean is this. There have been occasions, haven't there, when the first time you saw a juvenile, the subject of a 406 petition, is when the court committed him to Haverford State Hospital, and directs the hospital to evaluate and observe that person, and after doing this evaluation and observation, you then go back to Harrisburg and report your findings?

A. That happens on occasion, yes.

Q. And that period of time that you have the juvenile for that observation and evaluation is 10 days?

(15) MR. ROTH: Objection to this line of questioning, again, based upon the fact the question is argumentative. Also, by asking that question, you are trying to mislead the witness.

BY MR. FERLEGER:

Q. (Continued) Those occasions when you have gotten the juvenile from the court, when you first see the court—when you get the court papers and records, and are told that this is a court commitment to evaluate and observe—those occasions have happened, haven't they?

A. Yes.

Q. In that case, at some future point, you have gone back to the court and told the court or Master your recommendations and evaluation?

A. Correct.

Q. That takes how long, from the time a person comes in under Section 406 and the time recommendations are made to the—

MR. ROTH: I object to this questioning, again, based upon the fact, number one, the specific question is misleading. The issue is commitment under 402 and 403. Counsel is trying to mislead and draw a parallel between 406 and (16) 402 and 403. Furthermore, if I understand correctly, juveniles 18 and under, 406 applies to everyone.

BY MR. FERLEGER:

Q. (Continued) Answer the question.

A. Your question is: how long does it take? I have to answer you: it takes as long as the court specified. It may be 10. It may be 30. It may take 60. It is specified on the commitment by the court.

MR. ROTH: May I cross-examine at this point, or do I have to wait until the end?

MR. FERLEGER: I think we should wait.

MR. ROTH: Fine.

BY MR. FERLEGER:

Q. Of the juveniles now in your care at Haverford State Hospital, can you tell me how many are committed under Section 402, how many under 403, and how many under 406?

A. You'll have to allow me a moment to count.

Q. Do I have a copy of the document in your hand?

A. You have a copy.

MR. ROTH: That question has already been answered, to which you commented on and we replied to. It is a matter of record. You (17) can find your answer there, too. Furthermore, the current status, as I understand your question—

A. (Continued) I can't answer you currently, as I am answering as advised by your staff, to take the word "currently" to apply to the date we received notification of your deposition.

Q. Whatever you have on your list and what is the date?

MR. ROTH: As long as the date is reflected, and you can answer that approximately.

BY MR. FERLEGER:

Q. (Continued) Do you have a list with you today of the juveniles at Haverford, their ages and commitment sections?

MR. ROTH: Objection. I would appreciate her answering one question at a time.

MR. FERLEGER: I withdraw my previous question.

BY MR. FERLEGER:

Q. (Continued) Do you have a list here today?

A. Yes, I have such a list.

Q. May I have such a copy of it?

A. You may have a copy, but not now, because I don't (18) have one. We have a copy of the data abstracted from all the charts, so to have the information.

MR. FERLEGER: We can save some time if you are agreeable that when I make a copy of this list, that can be adopted as part of her testimony.

MR. ROTH: I would like to see the list. I would like to—am I correct in assuming the people whom you are representing, Mr. Ferleger, have given you their consent to see any records or charts about them; in other words, not only representing them in name, but in substance, and they have given their consent for you to see any information about them?

MR. FERLEGER: Yes. Our complainants have given us authorization, and the hospital to release records to us.

MR. ROTH: As part of the record, if any patient comes against the record to indicate—as you have indicated on record now—that you have full consent of every patient whom you represent?

MR. FERLEGER: That's absolutely correct.

(19) MR. ROTH: Through the patient himself?

MR. FERLEGER: Through the patient.

MR. ROTH: As far as I am concerned, you can make a copy now. I notice that Dr. Armstrong has notes on the back of this. I would appreciate that just the actual typing and not her notes be copied.

MR. FERLEGER: For the record, these are two sheets of paper titled, "Class Action Suit," on which are four columns: Names, Age, Commitment, Assigned.

This will be marked as Exhibit A for identification.

(A document entitled, "Class Action Suit," was marked for identification as Exhibit A.)

BY MR. FERLEGER:

Q. Dr. Armstrong, the named plaintiffs in this case, Kevin Bartley, Steve Gentile, Leslie Levine, Vicki Mathews, and Mark Weand, are you familiar with these people?

A. Yes, I am.

Q. They have been patients at the hospital?

A. Yes.

Q. Have you consulted and read their medical records?

(20) A. Yes, I have.

Q. I would like to ask you a little bit about those people.

Kevin Bartley was committed, wasn't he, on November 30, 1971, by his mother?

A. That's correct.

Q. From your knowledge of him at the time he was committed and the time after that, he would have preferred not to have been in the hospital?

MR. ROTH: Objection.

A. Kevin—

MR. ROTH: Do you want to rephrase your question?

MR. FERLEGER: No.

MR. ROTH: Do you want to repeat it, please? I would like to hear it again.

BY MR. FERLEGER:

Q. At the time he was committed and after that, Kevin would have preferred not to have been at the hospital; isn't that correct?

MR. ROTH: Objection. First, I think I would like to make certain under what section Kevin Bartley came. Has that been established?

MR. FERLEGER: I think it can be (21) established by Exhibit A.

MR. ROTH: You are referring to a specific case. You ought to refer to the commitment procedure utilized.

What commitment procedure?

MR. FERLEGER: That wasn't part of my question. If you want to, you can ask that on cross-examination.

MR. ROTH: You better first get to whether he was committed or admitted.

MR. FERLEGER: That has nothing to do with whether he has objected.

MR. ROTH: You have asked whether he objected to commitment. The question is whether or not he was admitted or committed and the appropriate section.

BY MR. FERLEGER:

Q. (Continued) Do you know under what section Kevin Bartley was admitted or committed?

A. He was committed under Section 403 by his mother.

Q. On November 30, 1971, do you know?

A. That's correct.

Q. Was that against his will or with his will?

A. There is no evidence in the admission note or in
(22) his chart that indicates in writing that he objected.

Q. Dr. Armstrong, we are not confined to the record. I am asking you of your own personal knowledge of him.

MR. ROTH: Objection.

MR. FERLEGER: I haven't finished my question.

MR. ROTH: I know. I am objecting to the line of the question.

Go ahead.

BY MR. FERLEGER:

Q. (Continued) Of your own personal knowledge —first of all, do you know what Kevin looks like?

A. Certainly.

Q. Have you spoken to him?

A. Yes.

Q. Were you a psychiatrist at the hospital?

A. I was the director of the services under which he was under. Dr. Carl Hammer was the individual psychiatrist.

Q. Have you spoken, during the course of his stay, to Dr. Hammer about Mr. Bartley?

A. Certainly.

Q. Of your own knowledge, was Kevin Bartley willing and happy to stay at the hospital?

(23) A. Are you asking if he verbally expressed to me a desire to leave; is that your question? I don't follow your question.

Q. Of your personal knowledge, was Kevin Bartley a willing patient at the hospital?

MR. ROTH: Objection. Willing for what?

MR. FERLEGER: Willing to stay at the hospital.

MR. ROTH: Objection. My objection is based on the point, you can't ask another question unless you withdraw your other question: whether Kevin Bartley, after he was committed, immediately objected to it. She answered he had not, and you asked her whether he was a willing patient. My question is: which question do you want the doctor to answer? I object on the basis that if you are going to ask questions, let her answer them.

MR. FERLEGER: I have been waiting for an answer for a little while.

MR. ROTH: But you have asked two questions.

MR. FERLEGER: I asked more than two.

MR. ROTH: On this particular phase.

(24) BY MR. FERLEGER:

Q. (Continued) On Kevin Bartley, my first question is: was he a willing patient at the hospital? In other words, did he desire of his own volition to remain at Haverford State Hospital to get treated with whatever services your unit provides?

A. Then, I can answer you: yes and no. On occasion, he wished to go home with his mother, who, until approximately a month ago, did not wish him at home,

and on other occasions, he requested to stay. So, both are true: yes and no.

Q. Isn't it true; had it not been for his mother making the application, had it not been the fact that she had initiated the commitment, that he wouldn't have stayed there?

A. No, that's not true. He stayed until it seemed advisable, until he attained sufficient ego control and behavior control. He was given to explosive outbursts.

Q. Did he think he had a problem with his ego control?

A. He thought he had a problem controlling his temper.

Q. He stayed because it was medically advisable?

A. Psychiatric.

(25) Q. He needed to stay at the hospital because of a psychiatric opinion?

A. Well, I would say he did not accept this. We do fulfill the psychiatric needs through the care and facilities of the hospital.

Q. Did he disagree with that psychiatric opinion?

A. On occasions.

Q. Even when he disagreed—

MR. ROTH: Objection. You are harassing the witness.

MR. FERLEGER: I am in the middle of a question.

MR. ROTH: You are harassing the witness. You are going over the same question three times.

MR. FERLEGER: You don't know the end of this question. I am in the middle of it.

BY MR. FERLEGER:

Q. (Continued) Even at the time he objected, he would not have been free to leave the hospital, isn't that true?

A. No, that is untrue. The mechanism is set up for giving notice, providing that the applicant was willing, he would have been signed out against medical (26) advice, even though determined medically and psychiatrically that he remain.

Q. But under those procedures, if the applicant is unwilling, he couldn't have signed out against medical advice?

A. That's true. I qualified my answer by stating when he was ready to leave, he was in fact discharged and not retained for reasons other than psychiatric.

Q. On long-term leave and—

A. Short-term leave. That, I would like to qualify for the record, is for administrative purposes, in order to provide the child the service he needs, namely, transportation from two counties, to Delaware County Intermediate for specified schooling.

Q. Leslie Levine, do you know who she is?

A. Yes, I do.

Q. When and under what section of the Act was she committed?

A. Leslie was admitted on a 403 commitment signed by her mother on 10/11/72.

Q. Where does her mother live?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. (Continued) Where does she live?

(27) A. In suburban Delaware County. I will give you the chart.

Q. Where does her father live?

MR. ROTH: Objection.

A. In Florida.

Q. Are her parents married, separated or divorced?

MR. ROTH: Objection.

A. Divorced.

Q. You read her records, didn't you?

A. Yes.

Q. You read her records and also the other patients' under your care?

A. In compliance with your order, we have prepared summaries specifically for this deposition on all adolescents in the hospital, including the plaintiffs and all others, which includes those not under my care.

Q. May I have them, please?

(Discussion off the record.)

(Copies of patients' summaries were handed to Mr. Ferleger.)

BY MR. FERLEGER:

Q. Dr. Armstrong, I have received from you and your counsel summaries of the commitments of every juvenile now in your unit, or in your unit as of February 15th.

(28) A. In the entire hospital.

Q. Thank you. In the entire hospital at Haverford State Hospital as of the date noted, I suppose, on the summaries; is that correct?

A. No, as of Mr. Abramson's advising us, the date we received your deposition request. What is that, February 23rd?

MR. FERLEGER: I also received dated summaries of the named plaintiffs in this lawsuit.

For the record, for the named plaintiffs, as I said before, I received their consent to seeing their records.

(Discussion off the record.)

MR. FERLEGER: For the record, there are individuals whose brief summaries I have been given from whom we have not received specific consent. These are individuals who are 18 years of age or under, and who have been ordered by the court, members of the class, plaintiffs of this lawsuit.

MR. ROTH: I would just like the record to reflect—and Mr. Ferleger can correct me if I am wrong—that from the statement he has made previously, he has received the consent of (29) all patients to receive and review their medical charts and all material relating thereto.

MR. FERLEGER: I have received consent to look at records of both juveniles and adults at the hospital in two ways. With respect to the named plaintiffs in this case, I received, on individual sheets of paper signed by them, specific consent to see records, and specifying the hospital release those records.

With respect to other persons, including those persons whose summaries will be marked as Exhibit B, I have received consent to see their records by reason of a contract with Haverford State Hospital, approved by Dr. William Beach, a defendant in this case, Deputy Secretary for Mental Health of Pennsylvania, which allows access to all patients' records at the hospital.

MR. ROTH: I would like to make a statement. In addition thereto, I have been informed by—and perhaps misled by—the opposing counsel, that he had received consent from all patients in this case, which included permission to receive and review their records. With regard to viewing these records, and having (30) given these records under the belief and assurances by opposing counsel that he had received the consent of the patients, I hereby charge that unless he has received that consent, that those records are subject to the rules of confidentiality.

MR. FERLEGER: For the record, plaintiffs certainly agree to abide and respect the confidentiality of patients who plaintiffs represent and the plaintiffs in their class in this matter.

The contract with Haverford State Hospital, approved by Dr. William Beach, signed by Dr. Kremens, and approved by Mark Leopold, Assistant Attorney, in Paragraph 11, the hospital agrees to give access to all patients' records and to all areas of the hospital to its professional staff and members. We will abide by the same rules governing hospital personnel having such access.

My questions now are directed to specific summaries of the named plaintiffs from whom we have specific consent, which will be marked as Exhibit C.

(Individual patient summaries were (31) received by Mr. Ferleger from Dr. Armstrong and marked for identification as Exhibit B.)

(Individual patient summaries for named plaintiffs were received by Mr. Ferleger from Dr. Armstrong and marked for identification as Exhibit C.)

BY MR. FERLEGER:

Q. Dr. Armstrong, the statements in all these exhibits are true, aren't they?

A. Yes.

Q. As far as you know?

A. Yes, as far as I know.

Q. You are willing to incorporate them into your testimony?

A. Yes.

Q. With that, we can dispense with reading over every word?

A. Fine.

Q. With reference to Leslie Levine who was at Haverford, do you know where she is now?

MR. ROTH: Objection.

A. No, I don't.

Q. Do you know if she went to Florida to live with her father to complete the school year, as done in the (32) past?

MR. ROTH: Objection. The witness has already answered your question as to where she is since she left the institution.

BY MR. FERLEGER:

Q. Do you know if the patient and her mother agreed to your recommendations to individual therapy while living with her father in Florida?

MR. ROTH: Objection. There has been no foundation laid on this.

MR. FERLEGER: Yes, if this summary of Leslie Levine is true.

MR. ROTH: If you are going to indicate a part of it, indicate the foundation for it.

BY MR. FERLEGER:

Q. (Continued) Have you read the summary?

A. Certainly.

Q. Did you help prepare it?

A. Certainly.

Q. Did you in fact prepare it?

A. No.

Q. With reference to Leslie Levine and with reference to the summary and with reference to what actually happened to her, to your knowledge from medical records, (33) did Leslie and her mother agree to the hospital's recommendation of individual therapy while living with the father in Florida?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. (Continued) Will you answer?

MR. ROTH: No. I want to elaborate.

First, you have just admitted a summary of this person.

Second, you indicated you did not want to go through the summaries with her verbatim, and have already asked Dr. Armstrong if the summaries are true and accurate to the best of her knowledge, and she has answered yes.

Now, you are taking the summaries and admitting or deleting parts of them, and also asking questions about the child's care and treatment subsequent to her release from the institution.

MR. FERLEGER: No, I wasn't. All I asked is if she and her mother agreed to something. I didn't ask if anything happened to her after.

MR. ROTH: Would you like to make a statement of proof?

(34) MR. FERLEGER: No.

MR. ROTH: Then I wish to register a special objection.

BY MR. FERLEGER:

Q. (Continued) Answer the question.

MR. ROTH: Please repeat the question.

BY MR. FERLEGER:

Q. Leslie—do you know her mother's name?

A. Her first name?

MR. ROTH: Objection. It's not relevant.

BY MR. FERLEGER:

Q. Her last name is Levine?

A. Yes.

Q. While Leslie Levine was at that hospital, did Leslie and Mrs. Levine, her mother, wish the patient to live with her father in Florida?

A. Mr. Ferleger, I will answer your question by stating that at the last family conference with Dr. Lustig, who was Leslie's individual and former therapist, they agreed that she would live with her father upon discharge and then they would follow the child on individual therapy. That's the extent of my knowledge.

Q. Why didn't she go home to live with her mother?

A. As the summary indicates, part of Leslie's (35) diagnosis of adolescent adjustment reaction, was extreme

difficulty functioning within her mother's surroundings and with the siblings. It was not psychiatrically wise to repeat that living experience.

Q. And she did better with the father?

A. That's what the history indicates.

Q. With reference to Mark Weand, he was committed under Section 402, June 23, 1972, isn't that true?

A. I have June 24th.

Q. At that time, did he wish to become a patient at Haverford State Hospital, to your knowledge?

A. At the time of his admission he was exhibiting symptoms of being under the influence of unknown drugs—

Q. Can you answer this question, please—

MR. ROTH: Let her answer.

A. He was not able to respond appropriately to any external stimulus.

Q. Your summary doesn't show that he was not able to respond to external stimulus.

A. It says, "Still intoxicated."

Q. It says, "Extremely hostile."

A. I would say being intoxicated.

Q. "Being intoxicated," does that mean you can't respond to any—

(36) A. It does mean any. I would say so.

Q. Subsequently, he was referred to and seen by a psychiatrist?

A. Right.

Q. At the time, did he desire to remain and become a patient at Haverford State Hospital?

A. I can't answer that question. I don't know at that time.

Q. What was the first time you saw him?

A. As indicated in the record, he was placed in a closed unit and was seen by Dr. Harold Rashkis.

Q. What is the first time you saw him?

A. I was answering. When he was transferred to the open unit on 7/12, I then saw the patient.

Q. At that time, did he wish to remain at Haverford State Hospital and remain a patient there?

A. You will have to tell by what indications you wish. He gave no indication, written or oral, to the staff. He indicated—I have the date as approximately two months thereafter—that he wished to leave. At that particular time there was no written or verbal expression made.

Q. At that time later, two months, was he permitted to leave?

(37) A. At that time, for the record, he wrote to the Adolescent staff, not the hospital director, and he was not permitted to leave. It was felt he was not ready to leave, psychiatrically.

Can I add to my answer?

Q. Yes.

A. In addition, it is to be noted that approximately two months thereafter, on September 3rd, the patient was suspected of taking an overdose of drugs.

Q. Dr. Armstrong under some questions I am sure your counsel will ask on cross-examination, and it will save us a lot of time if you try to answer my questions and not anticipate things or add things.

MR. ROTH: I really don't think you can elaborate on a question you ask her.

MR. FERLEGER: Of course not. The fact that he attempted to take an overdose of drugs doesn't

mean anything about the staff not allowing him to leave.

MR. ROTH: Dr. Armstrong, you just answer his questions, no more, no less.

BY MR. FERLEGER:

Q. (Continued) Just in general, in your experience at Haverford State Hospital, there are some children (38) who are happy to be there and happy to get care, and there are some who aren't and don't want to be there?

A. No, I don't think anybody is happy to be in a mental hospital. There are some who are willing to admit that they have problems and who want care, and there are some who aren't willing.

Q. So, there are some who desire to be there and want to get treatment, and some who don't desire to be there and don't want treatment?

A. That's true.

Q. Some of these persons, juveniles, are committed there by courts; isn't that true?

A. True.

Q. Some are either signed in on application of their parents; isn't that right?

A. That's right, true.

Q. There are a number of individuals in your unit who have come in, juveniles, because they want to come in themselves; isn't this true?

A. They are.

MR. ROTH: Objection. I am sorry, counselor. I am not sure I understand the question. If I don't understand, then Dr. Armstrong may not.

(39) BY MR. FERLEGER:

Q. Are there some juveniles who have problems, who appeared stating "I need psychiatric help. I want to be a patient"—who presented themselves, without their parents?

A. Yes.

Q. Are they accepted as patients?

MR. ROTH: Objection. Can you indicate what you mean by "juveniles"?

MR. FERLEGER: For all purposes, when I say "juveniles," I am referring to persons 18 years of age or under.

BY MR. FERLEGER:

Q. (Continued) Are people like that admitted?

A. They can only be admitted under the Mental Health and Retardation Act, which means that they must have someone, either a parent or guardian, and in the absence of either, someone to make a loco parentis application for them to get in.

Q. So, persons 18 years of age or under who wish to be committed and their parents refuse to make application, you don't take them in as patients?

MR. ROTH: Objection. I think the question has already been answered.

(40) BY MR. FERLEGER:

Q. (Continued) You can answer it.

A. There are methods by which we can.

Q. What methods?

A. We would contact the parents and contact the county agency, in this case, the Child Care Agency of Delaware County, and attempt to have guardianship

changed from parent to agency, and have the agency commit the child.

Q. Over the past four years, how many times has that happened?

A. I can't give you a number.

Q. Approximately how many per year?

MR. ROTH: I will register an objection.

A. I am not good at making estimates. It happened not infrequently. I can't give you a number.

Q. In your treatment program of juveniles, do you have a different program for court committed patients, as opposed to patients who are committed under 402, or 403, or is it the same program?

MR. ROTH: Objection. I would like counselor to specify whether people are treated differently, if that's what he is getting at, in terms of psychiatric help; is that your (41) question?

MR. FERLEGER: By treatment, I mean professional psychiatric programs.

MR. ROTH: You are asking about professional—you are asking about whether participation varies according to what section of the law—

MR. FERLEGER: That is a better phrasing.

MR. ROTH: Fine.

A. No. The program is set up to meet the needs of individual children, and the type of commitment has no bearing, except wherein the child—let me see how you should record this. You will need a closed facility for approximately a year or longer for someone who is committed under a murder one charge. Otherwise, for 408 or

406 court commitment: are treated, given ground privileges, and accessability to adolescent closed and open buildings, as their condition indicates.

Q. As their condition indicates, except for extraordinary cases, some criminal charge or court orders, otherwise it makes no difference what section the person is committed under?

MR. ROTH: Objection. You are misleading the witness.

(42) MR. FERLEGER: Why doesn't she tell me?

MR. ROTH: You are just taking her answer and turning it around to mislead her. I object to her answering that at all. You are misleading her completely. She just testified, as I understand it, that it depends on the needs of the person who is admitted—if you heard the beginning.

BY MR. FERLEGER:

Q. Then when you say, "Depending on the needs of a particular patient," then you are—

MR. ROTH: Are you going to specify the specific sections and use that, or I feel I must reject the premise of your question.

MR. FERLEGER: If Dr. Armstrong is mislead, I am sure she will tell you.

THE WITNESS: Okay. I am mislead.

BY MR. FERLEGER:

Q. (Continued) Thank you. Your answer earlier, with reference to—concerning whether the professional treatment program differs upon the court commitment,

what I understood you to say is that except in certain exceptional circumstances— the example you gave us is someone who needs a closed facility because of a (43) murder one charge—except in those exceptional circumstances, the treatment does not vary because of the type of court commitment—voluntary or court commitment?

A. Isn't that what I said?

Q. I am asking you.

A. That's what I said.

Q. Now, in your experience, what relationship have you seen between the progress and outcome of the treatment of juveniles with reference to whether they were committed by court or committed through application of the parents?

A. I can't answer that. The only way I could tell is if we did adequate research.

BY MR. ABRAMSON:

Q. Along that line, but not trying to ask a question that might require extensive research, when you have your meetings with different patients that come under the adolescent unit—

A. Adolescent Service.

Q. —Adolescent Service, do you seem to get the impression from them there may be some antagonism, based on the manner in which they were committed? Should I explain that more?

(44) A. Yes.

Q. In other words, what I am getting at: you meet with juveniles and you see them in your office personally, as I understand it, and you also observe them in the building, and I believe you have also seen all the patients who are currently there as of February 23rd. So, what I am sort of getting at is: do you feel you ever get any feedback

from them with reference to the manner in which they were committed? Do they complain to you or give any specific comments about the commitment procedure? Do they feel any abuse as far as they are personally concerned? Do you get any kind of a feedback from young people?

MR. ROTH: I object to this line of questioning. It is completely irrelevant on the fact there are provisions in the Mental Health Act which qualify why a person is court committed.

I even question whether or not there is any relevancy at all to this line of questioning.

I would request an offer of proof.

BY MR. ABRAMSON:

Q. (Continued) Answer the question.

A. Did I notice as the administrator of the unit, any difference in the attitude of the kids toward their (45) treatment, with reference to the kind of commitment?

Q. No, sort of getting away from the distinction between types of commitment now.

The fact that you are there on a permanent basis, and you have certainly, I believe, a great deal more contact with the patients, especially with the juvenile patients, than we do—

A. I have contact only with juveniles.

Q. —in that sense, I thought you might be able to enlighten us as to any feedback that you have received from juveniles in reference to their commitment, whatever section they were committed under; do you ever have comments from them?

A. Whether they are placed there against their will or with their will?

MR. ROTH: I object. I think Dr. Armstrong has answered that in a general term before, when you said whether people like to stay at the institute or not. I think she adequately answered that. You are giving a general question, yet you want her to answer it specifically.

MR. ABRAMSON: Perhaps I can be more specific.

(46) BY MR. FERLEGER:

Q. Can you answer the question?

A. No, I can't. I don't understand it.

BY MR. ABRAMSON:

Q. Have you ever had one of the juvenile patients make a statement to you concerning the manner in which he was committed?

A. Certainly.

Q. Have these statements from juveniles, minors, concerning the manner in which they were committed, ever reflected any dissatisfaction on their part?

A. Certainly.

Q. Do you feel, professionally speaking, the manner in which they were committed may have had a negative effect on their psychological well-being or mental well-being?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. Can you answer it?

MR. ROTH: The objection is founded upon the basis of the Act itself, where the hospital doesn't admit anybody it feels doesn't need help.

MR. FERLEGER: Dr. Armstrong can still (47) give her personal opinion.

A. The manner in which they are committed hasn't any negative effect on their psychological well-being.

I think the only way I can answer your question is to address myself to the question of someone's being there of their own volition or not being made available of the treatment, and it makes no difference under what manner one is committed, be it loco parentis, or parent, or court. Whatever the circumstance, when someone is unwilling to accept treatment, it is difficult to treat them. The fact they are unwilling is negative psychologically, not the manner.

Q. Thank you. Dr. Armstrong with reference to juveniles who were signed in by their parents at the hospital, do you think you just, professionally, would have a better chance to treat these juveniles if they were committed by the court, as opposed to having been signed in by their parents?

MR. ROTH: Objection.

A. I would have to answer that question the way I answered previously. In my professional opinion, where I am not concerned with the legality, but the treatability of an individual, it matters to those of us as therapists, whether the person presents himself (48) as willing or unwilling. The agency that does the unwilling commitment is not so relevant.

Q. So you don't think it makes such a difference whether the juvenile is committed by his parents, as opposed to having been committed unwillingly by the court?

A. I am sure it makes a difference.

Q. What difference?

A. By the fact that parents—and parents on whom they thrive—have a psychological attachment to their children.

Q. What is the difference—do people have—to children, as opposed to the court, which has no psychological attachment?

I know that is a difficult question.

A. I'm afraid it depends on the individual case.

Q. In cases where you experienced contact, can you tell me what difference it makes to the particular child?

MR. ROTH: Objection. You are going on hypotheticals.

MR. FERLEGER: I am asking on a specific instance.

MR. ROTH: What instance are you referring (49) to?

MR. FERLEGER: In specific, the instance of the children mentioned in Exhibit A.

MR. ROTH: Mark Weand or the entire list?

BY MR. FERLEGER:

Q. (Contniued) Just, if you would, like, outline for us, in your discretion, persons signed in by parents—tell us what difference it made to them in their case or their treatment, whether they were committed by their parents, as opposed to court?

A. The only way I can answer that is to go into each and every individual case. I couldn't generalize. There is no way I can give a generalized statement.

MR. ROTH: I object to the whole line of questioning. What you are doing: you are asking her for

an assumption of how it differs for one who is court committed, how it differs for one voluntarily committed, and how it differs for one who is court committed, and I think the rules speak for themselves, in commitment procedures. She has indicated several times it is impossible to answer that question.

MR. FERLEGER: I am asking for her (50) professional opinion, not an assumption.

BY MR. FERLEGER:

Q. In the Leslie Levine case, that is the case where I understand she didn't get along with her mother and siblings, and her mother is the applicant for her commitment. In that case, would it have made any difference to her or to her treatment if the court had committed her, as opposed to her mother applying for her commitment?

A. I can't answer that. That presupposes knowledge I don't have. In qualifying the admission, it was not because she didn't get along with her parents or her mother, but she can't behave appropriately. Specifically, she chased her mother with a kitchen knife and threatened to kill her.

I can't answer that it matters what agency committed her.

Q. Do you think the hostility that she evidenced toward her mother was increased or decreased by the fact her mother surrendered her to the hospital against her will?

A. My judgment is that it would be increased. Whether that in fact occurred, I can't say.

Q. Wouldn't there be less or an increase in hostility (51) or none at all if an impartial court admitted her?

A. I don't know.

MR. ROTH: Objection. She has answered that question repeatedly now.

BY MR. ABRAMSON:

Q. Dr. Armstrong, I notice on the list of juvenile patients, which was labeled Exhibit A, names of two young people in particular that attracted my attention. I would like to direct questions about them.

One is a young man, Allen Moss, whom I believe is currently still at the hospital.

A. That's correct.

Q. Specifically with reference to Allen, has he indicated to you or any member of your staff any facts with reference to the manner in which he was committed? Perhaps I should add the exhibit also shows he was committed under Section 403 of the Mental Health and Retardation Act. His records would show that he was admitted by his parents; is that correct?

A. That's correct.

Q. Has he indicated to you or members of your staff, any specific comments concerning the manner in which he was admitted?

A. I have not heard of any. Mr. Moss is directly (52) the patient of Dr. Gus Kratsa, K-r-a-t-s-a. Whether at individual therapy he has given some indication, I don't know.

Q. In other words, in the summary, there are no notes making reference to his original admission to the hospital or anything that took place at that time?

A. There are no notes in the summary.

I can add he was transferred from the University of Pennsylvania, and he admitted to being depressed and suicidal.

Q. Doctor, with reference to the third female patient, Deborah Geiger, the exhibit shows her age to be 16, and the type of commitment, under Section 403 of the 1966 Act, and I believe the specific record of her commitment shows she was also committed by her parents.

A. The record so states, Mr. Abramson, however, it also indicates that she wished to be committed, and it was impressed upon her by Dr. Kratsa that under the Mental Health Act, it was necessary that her mother sign her in.

It is a general requirement of the Mental Health Act that we ask the juveniles to sign the 403 paper themselves.

(53) Q. But Allen Moss, how did he come to get to the hospital?

MR. ROTH: Objection.

BY MR. FERLEGER:

Q. How did Allen Moss come to be a patient at the hospital?

A. The social worker from the University of Pennsylvania called our in-take social worker and arranged a transfer from the University. He was deemed to be too suicidal to remain in their setting, which is not a psychiatric hospital. He was in their ward.

Q. Then his parents signed him in?

A. Yes.

Q. When did his parents sign him in, as of what date?

A. As of 1/10/73.

Q. When was he transferred physically from the University of Pennsylvania?

A. The same day.

BY MR. ABRAMSON:

Q. So that I can assume then, the specific records that you have, the summary for Deborah Geiger, don't indicate anything with reference to her admission, other (54) than the comments you have already made?

MR. ROTH: Objection. That is misleading, Mr. Abramson. You indicated, "according to specific records of the summary."

MR. ABRAMSON: I am sorry.

BY MR. ABRAMSON:

Q. (Continued) According to the records of the summary you have here before you, doctor, can I assume then, other than the comments you have made, there is nothing else making reference to what took place at that time?

A. No, you can't assume that. The entire chart has additional data. I have extracted some material.

Q. The summary doesn't show additional information concerning her admission?

A. You have a summary before you. I don't see that it has any additional information.

Q. From your knowledge of her specific chart, do you recall any specific information on her chart concerning her admission; from her chart, which is not with us today, do you recall any specific information concerning her admission?

A. That she expressed a desire to Dr. Kratsa to come to the hospital. It's present on her admission, (55) yes.

Q. From your personal knowledge, could you convey any other information concerning her admission, other than what you have already given us?

A. What kind?

Q. Concerning the manner in which she was admitted, her attitude at the time, any facts?

A. She was interviewed in the open unit. Her family was subsequently interviewed, and she requested admission as an alternative to running away. She was considered to be quite upset, despondent, and in need of some treatment, and perhaps the living facilities of the hospital were available and the open unit was offered to her, which she accepted.

Q. Do you recall any information which has come to your attention from a member of your staff concerning the manner in which her parents made her available to your staff at the hospital; in other words, do you have any information concerning how she got to the hospital, other than the fact she came with her parents?

A. Her mother drove her.

BY MR. FERLEGER:

Q. With all the experience you have had with juveniles, would you just tell me—and this is an (56) open-ended question—whether or not you see any reason, or what reasons you do see for juveniles not to be entitled to a 406 court hearing before they can be presented to the hospital against their personal will?

MR. ROTH: Objection.

MR. ABRAMSON: Will you talk to that issue, please?

MR. ROTH: Dr. Armstrong is not qualified to testify on law as you feel it should be.

MR. FERLEGER: I do not wish her to testify on law.

MR. ROTH: You have agreed to her qualifications as an expert witness with regard to her treatment of juveniles specifically, and you have focused on these questions, and in part, you have gone awry.

As far as I am concerned, you are turning this into a fishing expedition. If that is going to continue, I will make the appropriate motion to dispense with the deposition.

BY MR. FERLEGER:

Q. (Continued) Can you answer that question, please?

A. You will need to restate the question.

(57) (The reporter read the last question as follows:

"Q. With all the experience you have had with juveniles, would you just tell me—and this is an open-ended question—whether or not you see any reason, or what reasons you do see for juveniles not to be entitled to a 406 court hearing before they can be presented to the hospital against their personal will?")

A. You are asking for my individual opinion?

Q. Yes, as a human being and psychiatrist.

A. My opinion is only in that area in which I am qualified to speak, and that is quality medical care.

Were the 406 hearing a legal procedure set up to function in a rapid manner, so that the child involved could get adequate care as soon as required, there would be no reason. However, in reality, that does not exist, and I find that insisting upon a court procedure for the admission of an acutely ill child would deprive the child in some instances, in many cases, of rapid institution of adequate psychiatric treatment.

Q. The need for rapid institution and psychiatric treatment could be met, couldn't it, by some emergency procedure, don't you think?

(58) MR. ROTH: Objection.

A. As I understand the present Mental Health and Retardation Act, the emergency procedures under a 405 are extremely difficult to comply with and do not fit all the circumstances in presenting an acutely ill child. Specifically, one must be acutely and observatively homicidal or suicidal and have committed such an act in order to qualify. There are a number of ill children that do not fit that definition.

Q. You said in your answer before, if there was a 406 or other court procedure which would get this effective care quickly for acutely sick children, then, as a professional, that would be satisfactory to you?

A. Are you saying if there was only a court procedure or additional?

Q. If there were two proceedings: one where the child could come in to you and get the care, of his own personal volition, and the other one, where there was a rapid and fair court procedure.

A. I don't think that would, in my own opinion—I think that is too restrictive. I also think there should be a provision for adequately trained medical personnel to effect admission rapidly without requiring a court proceeding.

(59) Q. Would that go to adults as well?

A. I am not qualified to speak for adults.

Q. Are you a psychiatrist?

A. Yes. That's an unfair question, and I am not going to answer that.

Q. You are a psychiatrist?

A. That's correct.

Q. To your knowledge, is there anything different about acute psychiatric problems of adults, which would require that adults also have the procedure you are suggesting, where qualified medical personnel could commit them without a court hearing?

A. I will have to answer your question this way. Yes, I am a psychiatrist, and I have been trained to work with adults first, but I have not practiced adult psychiatry in eight years. There are considerable differences with the acutely ill child, as opposed to acutely ill adult, particularly with reference to the degree of personality growth. Therefore, I can't answer your question.

Q. What are those differences?

MR. ROTH: Objection. This has become a fishing expedition. We are supposed to be focusing on Sections 402 and 403 of the Act. (60) Now you are going off on a tangent about adults and children and are talking in terms of generalities. It is becoming a fishing expedition.

MR. FERLEGER: Mr. Roth, if you will read the complaint, the first cause of action of the complaint alleges violation of equal protection, in terms of the way two classes of juveniles are treated, as well as a difference in the treatment between adults and children.

MR. ROTH: Notwithstanding—

MR. FERLEGER: This is not a fishing expedition to ask questions not only proper on deposition, but even admissible in court.

MR. ROTH: That is questionable, Mr. Ferleger. I appreciate your unrestricted judgment that this is admissible in court.

Secondly, as far as the questions concerning juveniles, along with adults, I believe Dr. Armstrong has already testified, notwithstanding your repeated harassing questions about adults, that she not be asked to testify to the nature of adults treatment or anything of that sort, since she has not been exposed to (61) them for the past eight years, and does treat, specifically, juveniles.

THE WITNESS: We better qualify that. Okay? I will have to change my statement regarding dealing with adults. I certainly deal with adults as far as their being family members, and have, in the past four years, restricted myself to adolescent psychiatry, and no adult patients per se.

MR. FERLEGER: Thank you.

MR. ROTH: Dr. Armstrong does state she was trained first in adult psychiatry. I don't think you would want to impune her qualifications. I am just objecting to your—

MR. FERLEGER: The question I asked her: what are the differences in the acute psychiatric problems of adults versus children—

MR. ROTH: And Dr. Armstrong answered that one of the problems involved is the determination upon permanment development. Now, to go through the whole list of them, I suggest you consult your nearest book on psychiatry and look for yourself, otherwise, it would take forever.

You are talking in generalities. As (62) involved among children, psychiatry is—

BY MR. FERLEGER:

Q. (Continued) Can you tell us any major differences between adult psychiatric difficulties and child psychiatric difficulties?

A. That would, Mr. Ferleger, take the better part of an afternoon. I can't do that. There are multitudinous ego functions that are not developed to the extent that are adults', and to go into each one entirely is too involved.

Q. With reference to those differences in these illnesses between adults and children, those illnesses would make, in your opinion, a sort of different procedure necessary for adults and children?

A. I couldn't say that.

Q. Are there differences between psychiatric problems in children which, in your opinion, would make it essential there be different procedures for bringing them into the hospital?

MR. ROTH: I object to that line of questioning. I think, Mr. Ferleger, or I am—at least I hope I am—well enough aware of the Act to know there are different procedures for adults, as well as procedures for juveniles (63) in the case of their commitments or admissions.

MR. FERLEGER: Mr. Roth, I was not asking for or eliciting your opinions. I am asking for Dr. Armstrong's opinions.

BY MR. FERLEGER:

Q. (Continued) Can you answer that?

A. Tell me the question again.

MR. FERLEGER: Read it back.

(The reporter read the pending question as follows:

"Q. Are there differences between psychiatric problems in children which, in your opinion, would make it essential there be different procedures for bringing them into the hospital?")

A. There are differences between adults' and children's psychiatric problems. We have established that. Whether that, therefore, indicates a different procedure for admission to be followed, I can't answer that.

Q. In your psychiatric opinion—

MR. ROTH: She just indicated she can't answer it.

MR. FERLEGER: Let me try to clarify the question.

(64) BY MR. FERLEGER:

Q. (Continued) Psychiatrically, you can't say then, if I understand you correctly, there are differences which require different procedures; is that a statement of what your feeling is?

A. No.

MR. ROTH: Would you clarify the question, please?

BY MR. FERLEGER:

Q. Would you say what you said then?

MR. ROTH: Say your question.

MR. FERLEGER: My question—there is no need for me to repeat it. This deposition will show what the question is.

She said she can't answer specifically, and I am asking her to state her feelings.

MR. ROTH: She can't answer with a statement. You have asked for her professional and personal opinion.

MR. FERLEGER: Dr. Armstrong was about to say something.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, is your position that you cannot say that there are differences between (65) the mental illness of adults and juveniles, which would require different procedures for admission or commitment to a hospital?

MR. ROTH: Objection. Dr. Armstrong has already answered that question.

A. I didn't say I cannot. What I said was I cannot state, on the basis of the fact there are differences in the kind of problems that children have, as opposed to adults. That in itself, therefore, indicates a difference in admission procedures which should be followed. Certainly the child should be allowed the same facilities as adults. Specifically, children should be allowed to sign themselves into a hospital, assuming they have adequate judgment. This is one of the difficulties in dealing with a child, and what you have to determine upon examination at the time of admission by a qualified psychiatrist. That's one of the major differences, and that's their ability to judge situations adequately.

Insofar as the admission procedure followed, as a conclusion to the assumption and statement, there are differences between mental illness in children and adults, but I can't answer as to the procedure.

Q. In your opinion, do you think the judgment of (66) parents, or guardians, or persons standing in loco parentis is sufficient for proper commitment of children to mental hospitals?

A. I think, under the Mental Health and Retardation Act, at the time the child is examined—

Q. In your opinion, not under the Mental Health Act.

A. I think the answer is yes and no.

Q. Can you explain that?

A. There are some instances where the parents are qualified, the child would not be admitted, which is my answer, under the Mental Health and Retardation Act—the parents would be judged to be qualified. However, on occasions, parents' judgments could be questioned.

Q. Unless the professional person, you included, felt the parents were qualified to make the determination?

A. Certainly. To elucidate, a psychotic parent could not admit a child because he would be judged not to be competent to judge.

BY MR. ABRAMSON:

Q. In your experience at Haverford State Hospital —in your professional experience, can you recall any (67) specific incidents of what you would consider abuses of the admission procedure by parents of young people?

A. I think you are referring to a conversation we had, Mr. Abramson, in checking into the particular cases. The child we were discussing, I believe, was committed under Section 406, so I can't recall that.

Q. You can't recall any case in which a parent has, under Section 402 or 403, for reasons other than the best interests of the child—

MR. ROTH: Objection. I believe Dr. Armstrong has answered the question.

MR. FERLEGER: It was not asked. I believe she has answered that according to the Mental Health Act at the time when persons under 18 are admitted, those doing the application are judged to be competent.

BY MR. FERLEGER:

Q. Once those persons are judged to be competent, then the child is admitted?

A. If the child appears to need admission.

Q. Have you, in your experience, ever come across an incident—I want you to think about this carefully—where parents have used the fact that they were able to petition and could apply under 402 and 403—have (68) used that fact in order to manipulate the child or the Act, contrary to the psychiatric interests of the child?

MR. ROTH: Objection. That question has been asked and answered.

BY MR. FERLEGER:

Q. (Continued) Can you answer that?

MR. ROTH: Furthermore, on the basis of harassing the witness.

A. That is a difficult question to answer. At the same time, I don't know if you are referring to the Exhibit A list.

Q. I am not referring to any exhibit list. I am referring to your past four years at Haverford State Hospital.

A. I don't know. I can't attempt to give you an answer, no. I am sure it occurs.

BY MR. ABRAMSON:

Q. In reference to that statement, do I understand you to say the present admission procedure, as followed by Haverford State Hospital, in accordance with the Mental Health and Retardation Act, allows for such abuses in your opinion?

A. No, it doesn't, because the child is examined on admission, and that has to be based on a qualified (69) psychiatric determination that the admission is necessary psychiatrically.

Q. I think that, Doctor, what I am asking is: does the procedure as followed by Haverford State Hospital, in accordance with the Mental Health and Retardation Act, allow for abuses, not on the part of the hospital or on the part of the admitting physician or whatever, but on the part of the parents? In other words, in their motivation.

MR. ROTH: Objection. The question has been asked and answered.

BY MR. ABRAMSON:

Q. (Continued) I am not asking now for any specific incidents or anything like that. I am asking for your personal opinion as far as the procedure goes, whether it allows for abuses, not on the part of the hospital, but on the part of parents who signed it, to apply as a part of the admission process. They do speak to the admitting physician; they do have the opportunity to convey their thoughts and their opinions about their child or are given some consideration by meeting the physicians. Given those facts, as I understand them, does the doctor feel, personally, that the procedure allows for abuses on the part of parents, again, not on (70) the part of the hospital?

A. I don't think that that's an adequate question, because the child is examined by a qualified psychiatrist, and were the child, regardless of what the parents stated, not in need of hospitalization, the child would not be hospitalized.

BY MR. FERLEGER:

Q. Stopping short of the decision of whether the child is in need of hospitalization, let's assume you have examined the child and you decided, does the procedure, as Mr. Abramson asked you, allow for abuse, even in initiating the application?

MR. ROTH: I object to that question. Dr. Armstrong is a psychiatrist who examines and determines whether or not the patient is a prospective patient, let's put it that way, and is in need of institutional care. What motives are behind the parents' placement of the child into the institution is completely out of the scope and knowledge of Dr. Armstrong. She is not dealing with the parents in admitting the child.

MR. FERLEGER: You heard she does speak to the parents.

(71) MR. ROTH: But you are trying to use that as a weapon in saying the parents are abusing the procedure.

MR. FERLEGER: I am not saying that.

MR. ROTH: That is completely out of the scope of this deposition. Dr. Armstrong can, not only testify as a professional involved, but also in terms of whether or not the prospective complainant needs to be admitted.

BY MR. FERLEGER:

Q. (Continued) We haven't given her a chance to answer that question.

A. I can answer you only insofar as what I said before. The parents' motives are examined. The child also is examined, and if his admission is determined to be necessary, admission takes place.

Q. You have examined parents' motives?

A. I interview parents.

Q. And professionally, you consider their motives and try to make an evaluation of their motives?

MR. ROTH: Objection. Dr. Armstrong discusses the admission with the parents. She does not examine the motives of these parents, and these inuendoes made are incorrect.

(72) BY MR. FERLEGER:

Q. (Continued) Do you examine the motives of the parents? I think you stated you—

MR. ROTH: She does not. If you are going to mislead, I am not going to let her answer.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, do you understand what the word motives means?

A. You can explain it to me.

Q. Do you not examine the motives of the parents who seek admission and commitment of their child?

A. Generally, what I examine is the presenting problem of the child. At the same time, it is not possible to examine motives of the parents at all times.

Q. But sometimes?

A. It depends on an individual case, what the circumstances are involved.

Q. Didn't you state earlier, in answer to my question, that you did examine motives of the parents?

A. No, I interview parents.

Q. In that interview, as I think you answered earlier, you examine the motives of the parents?

MR. ROTH: Objection. She already (73) indicated she does not examine the motives as you have indicated. She indicated that she interviews the parents.

MR. FERLEGER: This record will speak for itself.

A. It's not the admission procedure to examine motives of applicants, but the admission procedure is to examine the needs of the child, based on the psychiatric problems the patient presents.

Q. One of the ways of doing that is by the information gotten from various informants.

MR. ROTH: Objection. It is misleading. You are saying information from sources other than the psychiatrist. From my understanding, it is Dr. Armstrong's testimony that the person is admitted based on the psychiatric evaluation of the child or juvenile in this case, as it is determined whether or not this juvenile needs to be admitted.

BY MR. FERLEGER:

Q. Dr. Armstrong, when parents apply to have their child admitted, the normal procedure is to speak also to the parents; is that so?

A. Yes.

(74) Q. And the parents talk to you?

A. Correct.

Q. Do they tell you things about their child?

A. Certainly.

Q. Those are things you consider in making your professional evaluation?

A. But it is—an attempt is continually made to base any admission or observation on historical data that's presented by the parents. It is not a specific examination of the motives behind the facts.

Q. The parents present you with historical data about the child and you try to evaluate that and find in it, whatever psychiatrically relevant things there are?

A. It is based on continual examination of the child. The data isn't taken at face value.

Q. Have you found a case where some or all of that historical data was incorrect or fallacious?

A. I would say any historical data is subject to the interpretation of the person presenting it.

Q. Have you found a case where the parents, in your opinion, intentionally gave false information about a child they were presenting?

A. I don't know how I would determine that.

(75) Q. Have you ever found that to be true, either later on through other conversations or through social work history records?

A. That's historical data related by parents which is fallacious in part?

Q. Yes.

A. I am sure that occurs. You are asking me for data I can't give you.

Q. In those instances where the information is fallacious or incorrect, the only way you have of checking that is by your asking the patient, or other individuals, or doing your own investigation?

MR. ROTH: Objection. It has already been indicated that when the child becomes a prospective patient at Haverford, that Haverford undergoes its own independent psychiatric examination.

BY MR. FERLEGER:

Q. (Continued) Okay. Can you answer the question?

A. You will have to repeat the question.

(The reporter read the pending question.)

A. Any investigation is made by the available data. The usual admission procedure is that we request any school records, neurological background, examinations, electroencephalograms, medical examinations, (76) preceding psychiatric evaluations, or other ancillary data be presented.

It is not the function of an admitting physician to be a private investigator or check out the total validity of each fact. This is usually when things are correlated with other data that's considered in the total evaluation, but the primary evaluation depends upon the presenting child and symptomatology.

Q. The presented child usually doesn't have a lawyer with him or her?

A. Correct.

Q. Do you interview the parents in or out of the presence of the child?

A. As you are familiar, there are multiple ways of conducting psychiatric examinations. Depending on the individuals background and preference, either the entire family can be interviewed together, the child and parents may be interviewed without other family members, the child may be interviewed individually, and the parents may be interviewed immediately.

Q. Are the parents under oath at that time?

A. No.

Q. Is the child under oath?

A. No.

(77) Q. When you interview the parents privately, is the child informed of the content of those conversations?

A. Certainly.

Q. In what way?

A. If the child is not present, then the usual procedure, at least at Adolescent Services at Haverford, is to ask the child if the child would like to remain present. If the child does not wish to do so, the contents of the interview are explained to the child.

Q. By whom?

A. The examining psychiatrist.

Q. So, in every case then where the parents are interviewed, the child can be present if she wants to, in your Service?

A. That's correct.

(A recess was taken at 12:00 o'clock.)

(The deposition reconvened at 12:10 p.m.)

BY MR. ABRAMSON:

Q. Dr. Armstrong, first I would want to ask you a specific question, in that what I would like to know is: since you have been at Haverford State Hospital, can you recall any incident in which you felt professionally that there was a juvenile at the hospital, for however short a period, who in your opinion, did not require (78) the facilities of the hospital for medical reasons?

A. I can answer that most specifically by stating: in the American Psychiatric Association's diagnostic manual, the diagnostic manual called a diagnosis incorrect as

based on the psychiatric factors found, and that diagnosis was given one child in four years, namely, Cheryl Ann Masagee, M-a-s-a-g-e-e.

However, in reviewing Cheryl's chart, she was placed in a hospital by a civil court commitment on a 406.

Q. With reference to this specific individual, may I ask how long she remained at Haverford State Hospital, not the specific number of days, but do you recall—

A. Approximately three months. To qualify that, it was necessary to: one, change custody of the child for her best interest from her mother who had pressed the court for the 406 commitment, to the child care agency of Delaware County, which needed a court hearing; and secondly, a suitable placement for her, in acting in her best interests, was required. The court proposed to place her in a juvenile detention home, which the Adolescent Service at Haverford State Hospital felt inadvisable, and the child did not wish. Subsequently, a foster home was found by the Legal Aid Vocational (79) Department and was accepted.

Q. Now, specifically with reference to the procedure at Haverford, when a young person at the time of admission is found to be in need of care or treatment under the Act, is it always possible for them to go directly to the juvenile building or Building 9; is it always possible for them to be immediately transferred to Building 9 for care and treatment?

A. The way the Adolescent Service is set up at this particular hospital, namely, Haverford State Hospital, the Adolescent Service operates both a closed service and an open service. The open services mentioned is at Building 9, and admission to the open service is contingent upon the child's ability to maintain adequate social behavior in an open setting.

Where the child is too ill or too impulsive and unable to contain their behavior, it is necessary that they be placed in the closed unit.

Q. In the event that a young person is found to be in a suitable state for the open unit, either at the initial admission procedure or following a period of time in the closed unit, will he immediately be transferred to the open unit, or is that contingent upon there being a vacancy in the open unit?

(80) MR. ROTH: I object to this line of questioning. I mean I don't understand the methodology of the admission and commission procedure attached in this case.

BY MR. FERLEGER:

Q. (Continued) Can I explain it, or is it clear what I am asking?

A. I believe I understand your question. I would like to, before I answer that, state two sentences which are not diverting from your question. The Adolescent Services as set up at Haverford is a service whereby admission to the service must be in accordance with certain criteria, and that includes some degree of order in the intellectual capacity for survival, in the open building. When their condition allows, they are transferred to the open setting.

Two, it is contingent upon the availability of the beds. However, the hospital administration has expanded the capacity for children a hundred percent in the past four or six months, so that in fact the requirement of waiting for a place is usually no more than approximately two to three days.

Q. Have you in your experience been confronted with a situation in which the young person was in the

(81) closed or locked building and it was felt that they were suitable for transfer to the open unit, but yet, this transfer was held up for more than the approximate period of two or three days because of non-availability of space for them?

A. Prior to the availability of the additional half of the building it was true, but again, as the general situation was, it was no more than the maximum of a week.

Q. Thank you. The next question is more of a general nature than a specific nature. Getting back to the admission procedure, when a patient comes in with their parent to the hospital, and at some point it becomes clear to the child he is being brought to the hospital to be evaluated, with the possibility they may be admitted to the hospital, do you feel professionally that the knowledge of their impending commitment or admission to the hospital may have an effect on the image, what they present to the admitting physician, or perhaps, on their mental state at the time of the admission procedure?

MR. ROTH: I object on the basis that this question has been asked before and answered before.

(82) A. It may. It would depend, as I answered before, on the degree of volition with which the child presents itself. If the child is willing to come, it's a positive effect. If the child is negative regarding admission, the knowledge may have an effect and it may not. There is no general situation that may be given.

Q. You mentioned there was a practice at Haverford State Hospital, I believe, where if the child was favorable to admission, that you often allow them to sign the formal papers, as well as their parents?

A. This is the practice of the Adolescent Service itself, and the child is requested to sign in all instances; and in my personal dealings, the child has so done.

Q. In all instances, as I understand you to say, this is where the child was favorable to admission?

A. Right.

Q. This question may seem rather basic, but do you feel that allowing them to sign themselves in is beneficial to—

A. It allows them to have responsibility over their subsequent fate. So, it is rather obvious—

Q. Responsibility over their subsequent fate?

A. In their admission.

(83) Q. In other words, so that they are on record as favoring it? Is that what you mean? Because I understand it wouldn't affect their release. The fact they signed initially would not require that they signed to be released?

A. If I can amplify the procedure of the Adolescent Service again: wherein a 403 voluntarily committed child, 18 or under, wishes to be released, they are so advised by our staff to write to the hospital director of their desire to leave, and within the 10 days subsequent, their parents are notified, either by the child, which is requested, or by the staff—and in all cases, by the staff—and a conference is held, and either the commitment is then recommended to be changed to a 406 or the child may be released. This is amplified in the present Mental Health and Retardation Act. Because, under the Act, it states that the applicant or someone acting on the applicant's behalf, must write to the hospital director—in this case, the child—and this gives them their constitutional right guaranteed them by law.

Q. If the applicant does not wish to consent in writing, solely by this fact, the child would not gain the release?

(84) A. Yes, it does not affect their release. It does in the Adolescent Service, however, in all instances that I can currently remember. There may be exceptions that have caused the social service to reflect their views, to change the commitment to a civil court commitment.

Q. But you don't know whether this procedure or other ones is followed in other facilities across the state?

A. I have no knowledge.

BY MR. ABRAMSON:

Q. With reference again to the admission procedure, in the event an admitting physician does not feel that the juvenile brought in by the parents is in need of care and treatment at the facility, is there anything, to your knowledge, to prevent the parents from then attempting to admit the child to another facility within the state?

A. No. To my knowledge, there is no legal machinery that protects the child. There is no central clearing agency that has all daily admissions and evaluations in a memory bank, so to speak.

(Discussion off the record.)

BY MR. FERLEGER:

Q. Do you have, Dr. Armstrong, all correspondence, books, records, and documents relating to placement (85) criteria of the Department of Public Welfare for admission or commitment of juveniles, as you were requested to bring?

A. I consulted with the hospital director regarding your request. Haverford State Hospital has no additional

records, documents, books, or correspondence relating to admission, other than the Mental Health Act itself.

Q. The Department of Public Welfare, do they have any other such records or documents?

MR. ROTH: I object to that. I don't think Dr. Armstrong can answer as to what they have. She can only answer for the institution she is employed by.

MR. FERLEGER: If she can't answer, she can tell us.

A. I don't know.

Q. Have you seen, Dr. Armstrong, the answers to the first set of interrogatories that were signed by Mr. Roth?

A. Yes, I have.

Q. Do you have them here?

A. Yes.

(The witness handed a document to Mr. Ferleger.)

(86) BY MR. FERLEGER:

Q. Now, in your experience at Havorford State Hospital, is it correct that the standards used for admission or commitment of juveniles and those standards used for adults are the same, namely, that they're based upon the Mental Health Act standards for the mentally disabled and in need of care and treatment?

A. I don't understand your question.

Q. I will rephrase it. What are the criteria for admission or commitment of juveniles to Haverford?

MR. ROTH: Objection. I am not certain I understand the question. Are you talking about a professional opinion, whether or not the child is in need of institutionalization, or the law itself?

MR. FERLEGER: I am asking what the criteria are.

MR. ROTH: With regard to what?

MR. FERLEGER: Admission or commitment of juveniles. You seem to—

MR. ROTH: I don't understand your question.

MR. FERLEGER: You seemed to understand it well enough in the interrogatories. I am (87) asking the same question you answered and gave your name to.

MR. ROTH: I would like the question clarified for the witness.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, what are the standards or criteria you used in an attempt of admitting—

MR. ROTH: Objection.

A. I would say—

MR. ROTH: I can object on behalf—

MR. FERLEGER: You can permit her to answer.

MR. ROTH: I am merely objecting on the basis of what I understand is the Mental Health and—

MR. FERLEGER: You are answering for her, and your objection is fine, but do not answer for her.

MR. ROTH: I am not answering for her.

A. The criteria are the same criteria as in the Mental Health and Retardation Act itself.

Q. Which are what?

A. I don't have to read the entire thing?

(88) Q. The criteria you used from the Mental Health and Retardation Act for admission or commitment of juveniles to a facility?

MR. ROTH: At this time, would you like to stipulate as to what section, 402 or Section 403 say, or would you have Dr. Armstrong read it into the record?

BY MR. FERLEGER:

Q. (Continued) Read into the record that portion which gives the standards and criteria, if they are used, for juveniles.

A. The entire listing of things which are under the mental disability statement, which are under Article 1.

Q. What section of that; what section of the Act?

MR. ROTH: I object first, on the basis I don't know where you are going with this line of questioning. I would like an offer of proof before we get into the Mental Health and Retardation Act of 1966.

BY MR. FERLEGER:

Q. (Continued) You are referring to Section 102, to the definition of mental disability; is that correct?

A. That's what I am referring to.

(89) Q. And if I understand you correctly, this gives the definition of who suffers from mental disability, as defined there, who would be eligible for commitment?

A. Correct.

Q. To your knowledge, that definition of mental disability is also used for admission or commitment of adults as well?

A. To my knowledge.

MR. FERLEGER: Dr. Armstrong and Mr. Roth, I think we have agreed previously that in order to dispense with the necessity of Dr. Armstrong having here all the medical charts of all juveniles who are presently patients at Haverford State Hospital and named plaintiffs, that plaintiffs' counsel will be permitted to examine the correspondence, book records, and documents at Haverford State Hospital. Do we agree, or do you want to add something?

MR. ROTH: My understanding is Mr. Ferleger has an agreement with Haverford State Hospital which grants him access to all the information that he has addressed himself to, and my direction would be that he would be allowed to review those records, and also, it (90) would be my understanding, as I hoped it was Mr. Ferleger's, that he would use those to the best interests of these patients.

MR. FERLEGER: No doubt about it. Just to clarify things, on Exhibit A, there are three individuals there whose names there are lines through.

THE WITNESS: They are for a 408 criminal court commitment, and in our desire to supply you with all necessary data, we overextended available information.

MR. FERLEGER: Our request did pertain to all juveniles.

THE WITNESS: Then you do want them.

MR. ROTH: Your request directs itself to voluntary admissions. Are you referring to No. 9 of interrogatories?

MR. FERLEGER: No. Our notice of deposition refers to all juveniles who are presently patients.

David Rhinehart, age 16; Elizabeth Schriber, age 14; and Stephen Willett, age 16.

MR. ROTH: As far as I am concerned, since you have access to the records and we have (91) addressed ourselves to that, you are permitted to review them according to those juveniles presently in the facility.

MR. FERLEGER: Your turn.

MR. ABRAMSON: May I ask one question?

BY MR. ABRAMSON:

Q. I wanted to ask: if a juvenile is a patient at the hospital under either Section 402 or 403, and a parent comes to the hospital and would like to withdraw the child from the hospital, and the hospital has no objection, does the hospital concern itself with the future disposition of the child?

A. Yes. That's a useful question, I think. The hospital and the psychiatric staff, the psychologist, the social service nurse, and the lab services are, as part of their agreement to offer services in the examination, care, and treatment of the child, are required to recommend outpatient treatment if there is indeed a recommendation.

In Haverford State Hospital's instance, the outpatient clinic has been discontinued, and therefore, outpatient care is referred to four base service units in Delaware County. In other instances, if private therapy can be arranged, that is recommended, in (92) addition to the Department of Family Therapy at Haverford State Hos-

pital. Haverford State Hospital has an agreement with those patients involved in family therapy to continue three months of outpatient treatment.

In all instances, if further treatment is recommended, specific recommendations are given to both the child and the parents. Where an additional agency is involved, such as the probation department, the probation officer is consulted prior to the child leaving, and reasonably, at least regarding the child's needs and the hospital's recommendations, requirements are set up. All liaison with any social agency is attempted to be implemented for the child's care, and are worked with and met with prior to discharge so that the child's care does not stop when the child is discharged.

BY MR. FERLEGER:

Q. If the parents want the child out—if he has given notice to withdraw the application and you feel the child needs inpatient care, then, as I understand your testimony today, there are two things that can happen to him: either the child would be permitted to sign against medical advice, or, in your judgment, might have to have some child care or other (93) agency press for court commitment?

A. That's correct.

Q. Of the people listed in Exhibit A, can you tell me if you know which persons are there as a result of your having to do—to ask for a court commitment when the parents wanted the child out?

A. When the parent wanted the child out?

Q. That's correct. Are there any people there?

A. There are none.

Q. So that doesn't happen very often, I guess?

A. I am sorry. There is a correction. Your question was—can you tell me your question again?

Q. Are there people listed on Exhibit A, with reference to whom the parents have asked the application be withdrawn, with reference to whom you have had to ask or have an agency ask the court for a 406 commitment?

MR. ROTH: Objection.

A. Never mind. You are focusing on whether the application is withdrawn?

Q. Yes.

A. You are asking me if there are any patients whom we have had to request the commitment be changed? You do understand the parents have a right to disagree with our request, and a child, where this occurred—(94) and the resolution of the case—Mary Lou Gallagher—against medical advice, because the parents refused to institute a 406.

Q. Could you institute a 406?

A. There is no way in which, at any time, the hospital can act in loco parentis with the parents' disagreement.

Q. Then what I stated before is incorrect; if the parents disagree with you, your only alternative is to have a child sign out against medical advice?

A. That's correct.

Q. The reason is, even though you personally administer psychiatric care, you are not in a position to apply to the court?

A. That's correct.

BY MR. ABRAMSON:

Q. Doctor, is it also true with reference to recommendations you indicated are often made following dis-

charge of a patient, when you make certain recommendations to parents for continued care or whatever you mentioned previously, again, the hospital has no machinery in which to expel the complaints?

A. No. However, it should be noted, our major emphasis is dealing with the child, and with the (95) exception of a very small percentage, the children themselves, once they are worked with, are advised of their need for treatment and they are given the available base service unit address, phone number, et cetera, so they themselves may seek out their treatment, regardless of their parents' desires.

Q. But if a patient, a juvenile, changes his or her mind, you don't have authority to expel him or her?

A. No. The probation office does. We do not.

MR. FERLEGER: If the child happens to be under probation.

No more questions.

Your turn.

Cross-Examination

BY MR. ROTH:

Q. Dr. Armstrong, let's take a hypothetical situation and follow it through. If a parent wishes to admit a child to your institution under Section 402 or Section 403 of the Mental Health and Retardation Act, what is the first procedure which you utilize?

MR. FERLEGER: Objection. We went through this before, and you objected.

MR. ROTH: That is not true.

(96) BY MR. ROTH:

Q. (Continued) What is the procedure you utilize?

A. The parent is referred to a designated social worker of the Adolescent Service, and what is stated as an in-take interview is arranged with the parents, is one instance. On other occasions and more frequently, the entire family is given an appointment and a joint interview with a psychiatrist and social worker is held to determine whether or not the child requires admission and care.

Q. From what you have indicated in your examination by Mr. Ferleger and Mr. Abramson, it appears that if a child is admitted, or applied for admission other than by his parents, then you make a psychiatric examination. Do you, at that time, determine, based upon your examination, whether the best interests of this child are going to be served by institutionalization?

A. (No response)

Q. In other words, do you determine that the child needs institutionalization, based on an independent psychiatric examination?

A. Certainly.

Q. Now, if this child does not need institutionalization, do you still institutionalize him?

(97) A. No.

Q. If the parents, for any motive other than the best interests of the child, try to petition for his admission into the institution, do you, nonetheless, still conduct an independent psychiatric examination to determine whether or not this child needs institutionalization?

A. Yes.

MR. FERLEGER: Do I understand you to be inquiring into the motives—whether Dr. Armstrong

inquires into the motives or reasons of the parents' interests in committing the child?

MR. ROTH: According to the rules of the court, I am completely within the realm of the examination placed upon the witness before.

MR. FERLEGER: I have to ask you to clarify the question in order to determine whether or not an objection is necessary.

Do I understand you to be asking Dr. Armstrong if she inquired into the motives of the parents, and as a result of that, if the motives are improper, she determines not to institutionalize the child?

(98) MR. ROTH: I will repeat my question for you, if you will listen carefully.

BY MR. ROTH:

Q. (Continued) Notwithstanding the parents' reasons for appliance for admission for their child, does the institution conduct an independent examination in order to determine if a child is in need of institution care?

A. Certainly. In all instances, I would say an examination of the child is made.

Q. Let's say the child is admitted to the institution. After the child is admitted to the institution, and without getting into what kind of care or treatment is provided by your institution, in the event that the child is deemed to be sufficiently capable, in accordance with whatever medical or professional terms you used, what do you do? Do you recommend to the parents, his release? What procedures do you utilize then?

A. Repeat that.

Q. For example, after somebody has been admitted, and because of your care and treatment, is now sufficiently capable to return to society and eventually, to the family home, what do you do at that time?

A. We recommend to the child that his discharge be (99) effected, and we notify the parents of the same.

Q. Usually, when you do that, do the parents comply with you?

A. Yes, usually.

Q. In the event that the parent wishes to release his child from your institution, can you, at that time, indicate to the parent whether or not it is in the best interests of the child for him or her to be released?

A. Yes.

Q. Do you have instances where the child can be released, notwithstanding, medically, that it would not be in the best interests of the child to be released?

A. Certainly.

Q. If a child who is in the institution, objects to being institutionalized, do you follow that objection up at all with talking with anyone about it?

A. Certainly. The child is, as previously stated, advised by the entire staff to write a letter to the hospital director, Dr. Jack B. Kremens, and state that he wishes to leave the hospital. At such time, he is informed that he must inform his parents, and the staff also does. The staff, if the child is in need of further hospitalization, recommends the child's commitment, in 10 days as specified by law, be changed (100) to a civil court commitment, a 406. If the parents comply, this is done. If a parent does not, then the child is discharged.

Q. The summaries which you prepared today, on who were admitted, to wit, Exhibit B, were they—I believe—were the contents supplied in terms of requests,

on those summaries, which you discussed with opposing counsel?

A. Yes, they were, on an unofficial basis. Mr. Abramson has functioned as an unofficial advisor from Mr. Ferleger's staff for the Adolescent Service, and specifically, the Service's social worker, who made this form up for purposes of this deposition, and checked with Mr. Abramson as to its relevancy and completeness.

Q. Dr. Armstrong, questions have been asked of you with regard to examination, its length of time, under 406, as well as under 402 and 403. Is it your professional opinion that notwithstanding the procedures under which an applicant or court committed person comes into your institution, a substantial examination is carried out in order to determine whether or not this juvenile in this case needs institutionalizing?

A. Yes. I would add to my previous testimony, that (101) in this hospital's administrative procedure, there is an initial examination made by the psychiatrist, and is so designated as an admission note on the hospital record. Subsequently, for all adolescents on the Adolescent Service at Haverford State Hospital, there are routine studies done, such as an electroencephalogram, a neurological examination, a medical examination, and a complete battery of psychological tests and school evaluation, as well as a psychiatric evaluation. When all their data has been compiled, an entire staff conference is held, which is called a new case conference, at which point the complete case is re-examined and it is decided whether or not the child needs hospitalization, and at that same time, as well, an adequate treatment course is planned.

Q. Are periodic reports made and revealed to the patient and the parents for the basis of his continued need to be institutionalized?

MR. FERLEGER: I object. That is true of every hospital. That is standard and a required psychiatric practice that I don't think any institution in the State of Pennsylvania would say it doesn't follow. I would be horrified, and so would the doctor, if they (102) didn't continually work with the child and tell the patient what was happening.

BY MR. ROTH:

Q. (Continued) Would you answer the question, please?

A. Insofar as notifying the patient and his parents, or the applicant if it is not the parents, of the patient's status, the social worker is designated every 30 days to notify all admissions, regardless of types, of their status.

The parent or parents, or guardian, are met with, generally, weekly in some cases, to discuss the case. There is some social work counseling done in family therapy, and there are administrative parents conferences, the minimum of which are held once a month.

Additionally, as far as the patients' status and progress is concerned, in the Adolescent Service, there is a detailed progress report compiled by the Department of Research and Planning, in conjunction with Dr. Aaron Smith, wherein the patient's status is noted daily.

Q. Dr. Armstrong, you can correct me if I am wrong: one of the questions about the distinction between adult and juvenile was your admission procedure. Was your (103) answer that children by and large are unable to exercise judgment in determining whether or not they need care?

A. I would have to answer that question the same as I previously answered: yes and no. Some children are

able to exercise adequate judgment, depending on the nature and severity of their psychiatric condition, and their reasons thereof. To others, they are incapable. Their judgment is rendered non-functional by the basis of severe psychiatric problems.

Q. Dr. Armstrong, would it be your professional opinion that it is because the child, in particular, juveniles who are unemancipated—by that I mean living with their parents—could best be observed by their parents who can indicate to you that the child does need additional treatment or treatment per se?

MR. FERLEGER: Objection. Not only does Dr. Armstrong not know the legal definition of unemancipated, but your definition: someone living with his parents, is incorrect under the law of Pennsylvania. Under the law of Pennsylvania, a child can be living at home and still be emancipated.

Dr. Armstrong may know, because I wrote a letter, a legal opinion letter, with reference (104) to Trevor Haviland at the hospital, whether the child is emancipated and whether their family knows what this means legally.

I think that makes that question improbable.

BY MR. ROTH:

Q. (Continued) Let me rephrase the question.

In an environment where you have parents and a child living together, would you feel it is appropriate because of the relationship, because of the continual interaction among those people, for the parents to be best apprised in order to indicate to you or the institution that their child be in need of institutionalization?

A. I would have to answer that question as I did previously: yes and no. It would depend on the degree of stability and absence of mental disability, and the degree of maturity of the parents, the relationship of the child and the parents, and again, multitudinous other facts. In some cases, they would be the best observers, where the interaction is positive, and where the interaction is negative, they would not be.

Q. If parents would attempt to admit their child and your institution felt the admission was (105) inappropriate, your institution would not admit the child; is that correct?

A. That's correct.

Q. By and large, Dr. Armstrong, are most of the juveniles admitted or committed to your institution done so voluntarily by the child?

A. That requires the same estimate that Mr. Ferleger asked previously. Some are and some are not. To give you a figure, if you wish, I could count them from this list.

Q. Fine. Again, I am directing this question to the admission from the very outset, and not to subsequent development.

A. If the child requested admission; is that right?

Q. I am asking whether the child objected to his being admitted.

MR. FERLEGER: Go over each name and say—

MR. ROTH: No, I object to that.

BY MR. ROTH:

Q. (Continued) You do it on the whole basis. Say how many for and how many against.

(Discussion off the record.)

A. I think I need to qualify it. Do you mean (106) objected as far as I know at the time of admission, or objected at any time?

Q. Admission. I am also confining this to 402 and 403 commitments.

A. All right. Then those that did not object at all—

Q. Just strictly from admission.

A. Which must exclude six of the children on this list who are severely mentally retarded and cannot be considered competent—there are nine.

MR. FERLEGER: Who did not or did?

THE WITNESS: Who did not object—of 403?

MR. FERLEGER: And 402 is?

THE WITNESS: Okay. That is—

BY MR. ROTH:

Q. How many objected?

MR. FERLEGER: I think it is clear that if nine did not object, the rest objected, except for the retarded.

THE WITNESS: No, because in addition, some are severely psychotic and objection has no reference.

BY MR. ROTH:

Q. (Continued) If I understand, you are indicating (107) nine did not object, and that six were severely retarded, and some of the remainder are not able to exercise judgment in order to object and not object?

A. That's correct.

Q. And you indicated, such as Steve Gentile; is that correct?

A. For example, yes.

Q. Let me ask you this. As far as the named individuals in this particular lawsuit, could you tell me if they are currently in the institution?

MR. ABRAMSON: She has to answer your other question for us.

A. Just a moment. First of all, I am going to correct the first number. Speaking of those admissions, there are 16 that did not object at the time of admission. There are eight that objected, and the remainder are not competent, are severely retarded or psychotic, and cannot make an adequate judgment.

Q. Now, of those who objected at admission, what, if you will, deference did you give to their objection? How do you cope with an objection?

A. Well, it depends on individual instances again. If they are under a 406 or 408 as three were—

Q. So, three of the six who objected were under 408 (108) or 406?

A. That's correct.

Q. Court commitment? Some of the remainder of the remaining—

(Discussion off the record.)

BY MR. ROTH:

Q. (Continued) For clarification of the record, what you have indicated is 16 did not object, eight objected, and of the eight who objected, three came under the court committed procedure, with regard to Section 408 or Section 406; is that correct?

A. That's correct.

Q. Some of the remainder of those who objected were under 402 or 403, and there would be five?

A. Correct.

Q. Could you tell us what deference you gave to objections of those committed under 402 or 403?

A. They were advised to write to the hospital director of their desire to leave. We thoroughly researched their charts. It must be noted that on my list, only one of Mr. Ferleger's plaintiffs remains. However, of this list, none so instituted the writing of a letter to the hospital director, so there was no formal action taken by them, even though they had been (109) advised of the proper action to institute their discharge.

Q. Of those five, Dr. Armstrong, who objected, did you also notify their parents that they were objecting?

A. No, we did not. In this same procedure, if they would have written to the hospital director, the parents would be told at the weekly parent conference. They were not notified by a specific phone call. Had they initiated the writing of a letter to the hospital director—

Q. But the parents subsequently were notified?

A. Correct.

Q. Of the named plaintiffs in this case, how many remain in Haverford State Hospital?

A. None remain, however, Kevin Bartley is continued on short-term leave, as previously explained, for administrative purposes only. This allows him to procure transportation from both Delaware County and Chester County to attend Delaware County's intermediate special adolescent school.

Q. Do you know—

MR. FERLEGER: Is Kevin Bartley the only person on any sort of leave, and are the other people discharged?

(110) THE WITNESS: They are.

BY MR. ROTH:

Q. (Continued) According to your personal knowledge, do you know when those children objected, who are being represented by opposing counsel, whether opposing counsel proceeded to process any writs of habeas corpus to have these people released?

MR. FERLEGER: Objection. That doesn't have any relevance to either this proceeding or the court.

A. To my knowledge, they were filed.

Q. Dr. Armstrong, I just want to emphasize again: does your institution hospitalize anyone who does not require hospitalization?

MR. FERLEGER: Objection. That is repetitious of two of your questions and five of mine.

A. I cannot answer for anyone, Mr. Roth, as I previously stated. By experience at this institution as director of the Adolescent Service and my experience, of which 99 percent is with juveniles, I may say, on rare occasions I will do a professional colleague a favor and do his duty, which may require my admitting an adult. Very rarely under those circumstances do I (111) encounter an adult admitting their requiring admission.

Q. I gather from what you said, if your institution feels that a child no longer is in need of institutionalization, that you effect the proper procedure in order to have that child discharged or released; is that correct?

A. That's correct.

(Discussion off the record.)

BY MR. ROTH:

Q. Dr. Armstrong, in your professional opinion, do you feel that anyone, be it juvenile or adult—and this is

general—could best be evaluated by a psychiatrist, as your institution has, and by that procedure implemented, to determine whether or not that person needs institutionalization?

MR. FERLEGER: Objection. What do you mean by "best"?

BY MR. ROTH:

Q. (Continued) Could be evaluated by your institution in order to determine whether or not this person needs institutionalization?

A. Could you repeat that?

MR. FERLEGER: Objection. I think you are misleading the witness.

(112) BY MR. ROTH:

Q. In other words, what I am asking you is if any persons had wanted to be admitted to your institution—and I believe we are all well enough aware that we are now going into the realm of medical, professional, psychiatry evaluation—would it be your opinion that your institution could do this and does it?

MR. FERLEGER: Objection. The law is quite clear. Despite the requirements of the institution, a person cannot be committed solely on sight recommendations of any number of doctors. So, the fact that Dr. Armstrong thinks that—

MR. ROTH: I am merely asking her in her professional opinion.

MR. FERLEGER: Whether Dr. Armstrong feels that a doctor should have authority to evaluate and sign people into hospitals, in reference to adults in this state, it is quite clear that doctors do not have that authority.

BY MR. ROTH:

Q. (Continued) Can you answer that question without referring to any legal procedures, which Mr. Ferleger has led you to believe are incorrect?

MR. FERLEGER: I mean you are trying to (113) limit her answer.

BY MR. ROTH:

Q. (Continued) Can you answer my question, please?

A. Can you repeat the question again?

Q. From what I see, your institution, notwithstanding the voluntary admission, can make an independent determination to preclude admitting some patients?

A. That's correct.

Q. By the same token, can your institution make an independent determination to ascertain whether a person needs institutional care?

A. The institution does so by examination. The psychiatrist can, as I understand the present law, recommend hospitalization. They cannot institute it.

Q. Fine. But your institution can preclude the admission of someone under 402 or 403 if it feels that person does not need to be institutionalized?

A. That's correct.

Redirect Examination

BY MR. FERLEGER:

Q. What are the names of the persons in Exhibit A who objected to hospitalization? You referred to the number originally as eight in response to Mr. Roth.

(114) A. I want to make it clear that you are asking me for my professional opinion, which is based on memory, and it may well be that you will not find evidence of this in any record. However, in your questioning, you did not confine yourself to written facts, so I am giving my opinion.

One is Kevin Bartley; two is John Cross; three is Michael King; four is Ben Mosco; five is Thomas Hockenberry—we are including No. 405?

Q. Yes.

A. Graber, James.

And we are including 408; right?

Q. Yes.

A. Elizabeth Schriber.

Q. How about Rhinehart?

A. He preferred to come rather than go to jail.

Richard Burns; Anita Jenkins; Stephen Willett.

MR. ROTH: That's all?

THE WITNESS: That's the best I can do.

BY MR. FERLEGER:

Q. By my count, the number of names you have is 10 who objected.

A. You may be right.

Q. Of the remaining people, how many of them objected (115) to being hospitalized during the time of their hospitalization at any time during the time of their hospitalization?

A. We are using the definition of objected, as I have heard them object?

Q. Or you know from your associates that he objected or gave written notice?

A. None have given written notice.

Q. Of these other people.

A. None on the entire list.

Q. And how about in any way to staff members?

A. I have to add, insofar as my knowledge, it's incomplete.

What are you going to do about competent and incompetent people?

Q. If they have objected, then say so. Then say objected, but incompetent people. If they are incompetent, why don't you say—

A. I will run down the entire list.

Q. Except for the ten people you just mentioned.

A. Timothy Baer, objected, not competent.

MR. ROTH: You also included Timothy Baer as one of the 10, didn't you?

THE WITNESS: No, Bartley.

(116) A. (Continued) Mary Lou Gallagher.

Q. What about Suzanne Garrelli?

A. She came voluntarily.

Mary Lou Gallagher objected and signed out against medical advice, which I previously stated.

Stephen Gentile, not competent.

Pollock, Michael, objected and obtained his own court hearing. He is under 406.

Do you want the resolution of that?

Q. No.

A. Okay. David Rhinehart objected.

Michael Vantine objected.

David Parmet is not competent.

William Cutilli is not competent.

Thomas Taylor objects.

Peggy Ann Saunders is retarded, minimally competent, no objection.

Walter Lucas is not competent.

MR. ROTH: Had Walter Lucas objected?

THE WITNESS: Not to my knowledge. They are part of the Adolescent Service.

BY MR. FERLEGER:

Q. The others what?

A. In this list are even a number of children who (117) were not accepted into the Adolescent Service by virtue of either being too severely brain damaged or too retarded to participate in the program.

Q. Doctor, with reference to being accepted into your program or not being part of your program—

A. By virtue of present retardation, they are considered not competent.

Q. Which are they?

A. Walter Lucas.

Q. Point No. 2, you stated that the social worker, every 30 days, gives notice to the juveniles that are there under 402 or 403 commitment. In what way do they give that notice?

A. They verbally inform both the child and the parents. Either the parents are notified by telephone or informed by the weekly conferences.

Q. Is the fact that this information has been given to parents noted on the medical charts?

A. No, it is part of the routine procedure. However, in checking with the social service department, since the papers of a 403 are to be resigned every 30 days, the resigning itself is sufficient notification and, therefore, no notation is made.

Q. What is the notification of parents?

(118) A. That the child is notified verbally.

Q. Dr. Armstrong, two or three months ago, David Purcell of your staff kindly invited me to come to one of your staff meetings, and at that meeting, certain procedures happened, and I would like to describe it for you and ask you whether that procedure of your staff is typical. This follows with reference to what Mr. Roth asked you about.

A patient had given a letter to the staff, expressing his desire and intention, if permitted, to leave. This matter was brought before the staff members as an assembled staff of psychiatric aides, doctors, and there was a discussion by the staff of the person's history and progress, and there was a discussion about the person's family situation. Then, there was a consensus agreement that the person was not yet ready to leave the hospital, and the staff member who received the letter was instructed to tell the patient that right now, he can't leave.

Is that the normal procedure?

MR. ROTH: I object. First of all, you are doing the testifying about a conference which we haven't established whether Dr. Armstrong was part of.

(119) Secondly, if you want to testify, we can put you on the stand.

Thirdly, as far as the information goes, as far as I can gather, is strictly hearsay, and based on only part.

Now, if you want to ask Dr. Armstrong about the procedure that is utilized, you may do so.

MR. FERLEGER: Your objection is noted.

BY MR. FERLEGER:

Q. (Continued) Is that procedure that which is typically followed?

A. I think, as I previously stated, Mr. Ferleger, in dealing with children, particularly disturbed children which we are speaking of, one cannot have a typical procedure. There are general cases, but actually, there are many exceptions as well.

Q. The procedure I described, is that one which—

MR. ROTH: I object to that question, and again, because there has been no foundation laid appropriately in order—

MR. FERLEGER: Depositions don't require foundations.

MR. ROTH: We are questioning and (120) cross-examining Dr. Armstrong according to law, and accordingly I advise you with regard to questions and answers that may be asked, if the proper foundation is not laid for a question then it obviously is of no matter whatsoever. If you want to ask about the procedures, fine. If you want to ask Dr. Armstrong to be a little more help to you, you can ask if she is aware of this particular meeting, according to her personal knowledge. I do not want you to mislead her since I do not know for a fact that the actual situation which you allegedly stated has occurred, and asking her whether that procedure is a uniform procedure is questionable. I have no basis of knowing the validity of that conference per se.

BY MR. FERLEGER:

Q. (Continued) Dr. Armstrong, assuming hypothetically the procedure I described happened as I described it, is that one of the procedures for dealing with such a notice, that your staff follows?

A. Is it one of the procedures?

Q. Yes.

A. Hypothetically, okay.

(121) Q. Assuming the facts I stated are correct, is that one of the procedures that your staff follows?

A. That's one of the procedures. There is, however, and I would prefer to elaborate for you, an additional and more useful one, which is in accordance with our major purpose of being here, and that is what regards the child's best interest. As you are well aware, any effective treatment service is continually re-evaluated and reformulated. The therapeutic community has a general meeting wherein persons requesting those passes for brief periods of time and discharges are brought up. The patients themselves—the patient's consensus is noted for the central community, who then meet with the Adolescent Service and the staff gives their opinion. It is to be noted that the staff may agree to the patient's recommendation, however, in general, a consensus agreement is attempted to be made. So that is the most general procedure than the one you stated.

Q. What if the professional staff feel it is not in the best medical interests and the—

A. I would disagree with you: medical interests. I would say the best interests of the child.

Q. If the professional judgment about the best interest of the child conflicts with the community's (122) recommendations, then you would feel obliged to agree to that suggestion?

A. That's the truth. However, to date, that has not happened.

(Discussion off the record.)

BY MR. ABRAMSON:

Q. With reference to Mr. Roth's question concerning the follow-up—all of the procedures which take place while a young person is at Haverford, I notice in particular, with reference to Miss Vicki Mathews, in the summary prepared for her, there is reference made to this continual evaluation and coordinated efforts. In particular, I notice reference is made to the recommendation concerning Devereux School for this patient.

A. Yes.

Q. And my question is—I don't see it here on this summary—do you recall if the patient, Vicki Mathews, expressed any feelings as to her opinion of Devereux School being a boarding school?

A. Yes, I recall, specifically, Vicki Mathews' opinion. Victoria Mathews is one of the patients that fits the category of being non-volitional on occasions, and on other occasions she would admit to myself and Dr. Rosen that she had problems, and on other occasions, (123) she had not, and therefore, resisted any additional psychiatric care. As you can see by her record, she had been through both Irving Schwartz Institute and the Philadelphia Child Guidance Clinic before she reached us. This is a particularly difficult individual to handle, so that the recommendation for a private facility was made more on the basis of this being something that the patient and her family could accept, rather than feeling that our facility was incapable of handling her.

BY MR. FERLEGER:

Q. Where is Devereux School?

A. Devereux School is a multitude of schools. The main office is in Devon.

Q. Is it in Pennsylvania?

A. One is in Pennsylvania. One is in Massachusetts. One is in Connecticut, and one is in California, and one is in Texas.

Q. Do you know which branch Vicki is in?

A. Yes. As general director and director of that Adolescent Service of which we speak, it becomes necessary to deal with directors of similar residential settings.

Q. Can you tell me?

(124) A. Their recommendation was that she go to Texas, and that is indeed where she went.

Q. Do you know what town?

A. Victoria.

Q. Would you call Vicki Mathews a non-volitional patient?

A. At times.

Q. Is Mark Weand a non-volitional patient?

A. At times.

Q. And what about Leslie Levine?

A. At times.

Q. And Kevin Bartley?

A. At times.

Q. And what about Steve Gentile?

A. He was Dr. Hammer's patient, and his opinion is that he was severely psychotic and not competent to exercise judgment, and my comment is I feel his objection is one that you cannot take heed to. His objection is not realistic.

Q. Do I understand that he has made objections, but because of the medical factors you mentioned, you don't feel they have substance?

A. That's correct.

MR. FERLEGER: I have no further (125) questions.

Recross-Examination

BY MR. ROTH:

Q. Dr. Armstrong, now, we have been talking about objections, and I only have one question with regard to these objections. What is the nature of these objections? Are some of them inconsistent one day or they are objecting the next day, or complaining, or are they up and down, if you will, like a yo-yo, objecting one day, and something where they are objecting the next day? Do you have an instance of this sort with regard to that type of objection? Are these types of objections consistent and repeated?

A. Yes and no. Some indeed are reflections of the child's ambivalence toward their illness, such as Kevin Bartley, and Vicki Mathews, and Mark Weand. One day they feel they can handle the problems themselves. Then when confronted with their own behavior, such as Mr. Weand's drug taking or Miss Mathew's suicide gestures, such as lacerating their wrists, their behavior is difficult to deny and the patient acknowledges the presence of his problems and has some psychiatric difficulty. In other instances such as the case of (126) Mr. Burns, who is in under 406, his diagnosis is that of personality disorder. Without going into the nature of such a diagnosis, it allows for consistent repetitive resistance toward any communication and resistance toward being hospitalized.

Q. Dr. Armstrong, with regard to the number of individuals that you have in your institution, is your specific program running at full capacity?

A. Almost full capacity.

Q. Is there a great turnover in terms of your institution wishing to release juveniles once they have attained their prospective or whatever professional terms you utilize?

MR. FERLEGER: Objection. A great turnover with regard to the institution's desires?

BY MR. ROTH:

Q. (Continued) I said: a great turnover in the number of patients, juveniles.

A. Again, I would have to answer you that with Dr. Smith's research department, we are in the process of compiling adequate statistical data which I haven't currently been able to get compiled. I can't give you figures of our average length of stay or discharge and admission rate. All I can tell you is that some patients (127) stay for two or three weeks. Some stay for several months. Their lengths of stay are based on their need for hospitalization.

BY MR. FERLEGER:

Q. In the ambivalence toward hospitalization, asking to leave one day or objecting one day, and not the next, that is true of adults as well, isn't it?

MR. ROTH: Objection.

A. Some, I would say.

Q. Is it true of some adults?

A. Yes. One cannot generalize about any statement regarding the psychiatric status of one individual.

Q. It is true of some adults and some juveniles?

BY MR. ROTH:

Q. With regard to ambivalence, is ambivalence precipitated by the condition of the patient?

A. Yes.

MR. ROTH: Thank you.

MR. FERLEGER: I have nothing else.

(Witness excused.)

(Oral examination concluded)

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(128)

CERTIFICATION

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the oral examination in the above cause, and that this copy is a correct transcript of the same.

Patricia M. Kosmalski

I have read the foregoing transcript of testimony given by me in the above matter, and hereby certify that it is true and correct to the best of my knowledge and belief.

Witness' signature

(129)

EXHIBIT A

CLASS ACTION SUIT

Name	*Age*	*Commitment*	*Assigned*
Bartley, Kevin	16	403	Dr. Armstrong
Baer, Tim	17	406	Dr. Rosen
Cross, John	17	403	Dr. Rosen
Carrelli, Suzanne	16	403	Dr. Armstrong
Clark, Beatrice	13	403	Dr. Lustig
Geiger, Deborah	16	403	Dr. Kratsa
King, Michael	14	403	Dr. Rosen
Edwards, Elizabeth	15	403	Dr. Armstrong
Gallagher, Mary Lou	15	403	Mrs. Parrish
Gentile	17		Dr. Hammer, Ellen, [Illegible]
Golden, Sally	14	403	Dr. Armstrong
Hutchins, Judy	17	403	Dr. Lustig
McCauley, Mary Ellen	16	403	Dr. Armstrong
Pollock, Nick	17	406	Dr. Armstrong, Bob Schoenhultz
Mosco, Ben	16	403	Dr. Hammer, David Brosell
Hockenberry, Tom	15	403	Dr. Hammer, Kathy Olsen
Thompson, Terry	18.9	403	Dr. Lawson
Brehm, Nancy	18	403	Dr. Armstrong
Moss, Allen	16	403	Dr. Kratsa, Kathy Olsen
Graber, James	17	405	Dr. Kratsa, David Brosell

Name	Age	Commitment	Assigned
Rhinehart, David	16	408	Dr. Kratsa
Schriber, Elizabeth	14	408	Dr. Kratsa
Burns, Richard	17	406	Dr. Lustig, Bob Schoenhultz
Barnett, Willard	15	403	Dr. Kratsa
Vantine, Michael	15	403	Dr. Hammer
Osbourne, Sue	16	403	
Parmet, David	16	403	
Cutilli, William	17	403	
Jenkins, Anita	16	408	Dr. Wochiehowski
(130) Willett, Stephen	16	408	Dr. Kratsa
Taylor, Thomas	14	403	Dr. Lustig
Saunders, Peggy Ann	17	403	Dr. Rosen
Lucas, Walter	18.5	403	

(131)

EXHIBIT B

NAME: Baer, Timothy

AGE ON ADMISSION: 14 BIRTHDATE:

COMMITMENT: 1. Date on original and present: 5/15/69

2. Type on original and present: 404

3. Changes type and when: 10/16/72 406

ADMISSION: 1. Admitting Physician: Fong

2. Reasons for Admission: Homocidal & suicidal ideation. Hallucinating, phobic Ron-Rual

3. Who reported behavior: Family

DIAGNOSIS: 1. Admission Note: Schiz. childhood type

2. New Case Conference Note: Childhood schiz.

3. Discharge and date: Still in

4. Present:

PROGRESS: (Very brief summary of hospital courses; where admitted; doctor; what program; current status)

Long, stormy Hospit., mainly on closed wards; with multiple somatic complaints, physical attacks on staff, self-destructive behavior.

Presently on closed wd, on grounds, priv

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(132)

K.O.

2-21-73

NAME: Barnett, Willard, 14-6

AGE ON ADMISSION: 14 BIRTHDATE: 8-18-58

COMMITMENT: 1. Date on original and present: 1-8-73

2. Type on original and present: 403
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: 3 wks. of truancy; 3 days of uncontrollable behavior; threatened suicide
3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schizophrenia, simple

2. New Case Conference Note: None
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Dr. Kratza is his doctor.

Will had been transfered to Bldg. 9 once before, but apparently was not ready for an open unit & was transfered back to Bld. 4 On 2-20-73 he was transfered back to Bld. 9.

He is involved in O.T., A.T., RT & 2 group Tx.

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(133)
KO
DATE: 2-22-73

NAME: KEVIN BARTLEY

AGE ON ADMISSION: 15 BIRTHDATE: 11-4-56 PRESENT AGE: 16-3

COMMITMENT: 1. Date on original and present: 11-30-71
2. Type on original and present: 403
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Ivins

2. Reasons for Admission: Transfer from ESSH, temper outbursts, difficult to control
3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Organic Brain Syndrome with epilepsy. Personality disorder: explosive personality

2. New Case Conference Note: Explosive personality disorder with epilepsy.
3. Discharge and date
4. Present: On Short Term Leave since 11/23/74

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status.)

Kevin is on short term leave, attending the school program on the Hospital grounds.

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(134)
2/15/73

NAME: Burns, Richard

AGE ON ADMISSION: 17 BIRTHDATE: 12/18/55

COMMITMENT: 1. Date on original and present: 1/29/73; 2/2/73
2. Type on original and present: 406; 406
3. Changes-type and when:

ADMISSION: 1. Admitting Physician: Streker
2. Reasons for Admission: drug abuse & incorrigibility
3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: adjustment reaction of adolescence
2. New Case Conference Note: same.
3. Discharge and date

4. Present: unsocialized aggressive reaction of adolescence 308.4

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 9 for evaluation. Assigned to Dr. Lustig. Individual & family sessions. No medications. Evaluation continuing.

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(135)
K.O.
2-21-73

NAME: Brehm, Nancy

AGE ON ADMISSION: 17 BIRTHDATE: 1-12-55

COMMITMENT: 1. Date on original and present: 8-9-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Pt excluded from mothers home; previous drug use; previous admission to this hospital

3. Who reported behavior: Pt

DIAGNOSIS: 1. Admission Note: Adolescent adjustment Rx

2. New Case Conference Note

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Nancy is currently enrolled in the drug program on 1 No. Dr. Zal is her doctor. She is in the school program.

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(136)
K.O.
Date: 2-22-73

NAME: Carrelli, Suzanne

AGE ON ADMISSION: 16 BIRTHDATE: 4-16-56 Present Age: 16.10

COMMITMENT: 1. Date on original and present: 11-10-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Felix

2. Reasons for Admission: Suicidal ideation; chaotic family; has

3. Who reported behavior: Pt

DIAGNOSIS: 1. Admission Note: Schizophrenia, simple type with depressive features

2. New Case Conference Note

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Sue is a pt of Dr. Armstrong in Bld. 9. She is involved in the school program, and has group therapy 2 times a week. She goes home on weekends.

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(137)
Date: 2/15/73

NAME: Clark, Beatrice

AGE ON ADMISSION: 13 BIRTHDATE: 4/27/59 Present Age: 13

COMMITMENT: 1. Date on original and present: 1/16/73

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Armstrong

2. Reasons for Admission: episodic drinking, running away, & stealing "catatonia"

3. Who reported behavior: Mother & BSU psychologist

DIAGNOSIS: 1. Admission Note: deferred

2. New Case Conference Note: 308.4

Discharge and date

4. Present: unsocialized aggressive reaction of adolescence 308.4

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 9, assigned to Dr. Lustig. Receiving milieu therapy & family therapy. Discharge anticipated soon.

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(138)

NAME: Cross John

AGE ON ADMISSION: 17y-o- BIRTHDATE: 10/9/54

COMMITMENT: 1. Date on original and present: 2/19/72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Wicoff

2. Reasons for Admission: Talking incoherently suicide threats

3. Who reported behavior: Family

DIAGNOSIS: 1. Admission Note: Schizo—Aff. Schiz

2. New Case Conference Note: Acute Schiz. Episode

3. Discharge and date: Still in

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

2 Elopements

Presently AWOL

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(139)

K.O.

3so 2-21-73

NAME: Cutilli, Wm, 17 yo

AGE ON ADMISSION: 16 y. o. BIRTHDATE: 1-5-56

COMMITMENT: 1. Date on original and present: 1-3-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION 1. Admitting Physician: Dr. Buck

2. Reasons for Admission: Pt had been under treatment at Allentown State Hospital since Age 5. Pt can't speak.

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schiz., childhood type

2. New Case Conference Note: Childhood Schitz

3. Discharge and date:

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

3 so. Dr. Lawrence
Mute
In school program on 3S0
Behavior problem—irratic behavior

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(140)
K.O.
Date: 2-22-73

NAME: Elizabeth Edwards
AGE ON ADMISSION: BIRTHDATE: Present Age:
COMMITMENT: 1. Date on original and present: 11-16-72
2. Type on original and present: 403
3. Changes type and when:
ADMISSION: 1. Admitting Physician: Dr. Armstrong
2. Reasons for Admission: Suicidal gestures
3. Who reported behavior: Pt & social worker
DIAGNOSIS: 1. Admission Note: Adolescent Adjust. Rx
2. New Case Conference Note:
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Liz is a pt of Dr. Armstrong in the Open Unit Bld. 9. She in involved in the school program, & group therapy 2 x a week.

(141)
2/7/73
KO

NAME: Deborah Geiger, 16.7
AGE ON ADMISSION: 16 BIRTHDATE: 7-13-56
COMMITMENT: 1. Date on original and present: 1-17-73
2. Type on original and present: 403
3. Changes type and when: None
ADMISSION: 1. Admitting Physician: Dr. Kratza
2. Reasons for Admission: Chaos in life; multiple destructive tendencies
3. Who reported behavior: Parents
DIAGNOSIS: 1. Admission Note: Reactive disorder
2. New Case Conference Note: None
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Involved in the school program, group therapy 2 x a week. Dr. Kratza is her doctor.
Family Fx.
Mostly cooperative.
No meds

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(142)

NAME: Gallagher, Mary Lou
AGE ON ADMISSION: 15 BIRTHDATE: 9/15/57

COMMITMENT: 1. Date on original and present: Original 8/28/72 Present 10/26/72

2. Type on original and present: Original 403 Present 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reason for Admission: Rebellion, aggressive behavior. Runaway, threatening to take drugs. Refusing out-patient care.

3. Who reported behavior: Father, Mr. Joseph Gallagher Mother, Mrs. Gallagher

DIAGNOSIS: 1. Admission Note: unsocialized agressive reaction of adolescence.

2. New Case Conference Note:

3. Discharge and date 2/12/73 AMA

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Marylou was a pt of Dr. Armstrong in the Open Unit. While there, she had at least 2 serious episodes of drug taking, and 2 elopements, which necessitated her transfer to the closed unit.

She was admitted into the drug program at HSH on 2/6/73 on 2/12/73 she was discharged AMA.

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(143)

Date: 2-22-73

NAME: Steve Gentile

AGE ON ADMISSION: 17 BIRTHDATE: 3-20-54 Present Age: 18.11

COMMITMENT: 1. Date on original and present: 8-24-71

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Ivins

2. Reasons for Admission: Pt is extremely violent, striking family, biting father.

3. Who reported behavior: Father

DIAGNOSIS: 1. Admission Note: Schizophrenia, acute undifferentiated

2. New Case Conference Note: Schiz., Chronic undifferentiated

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt is under care of Dr. Hammer. At present he is in the closed unit. He has been in the Open unit at times, but became increasingly bizare & became assaulting to his father the last time he was in the Open unit.

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(144)

2/7/73

K.O.

NAME: Tom Hockenberry, 15.8

AGE ON ADMISSION: 15 BIRTHDATE: 5-28-57

COMMITMENT: 1. Date on original and present: Sept 20, 1972

2. Type on original and present: 403 (original & present)

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Bluitt

2. Reasons for Admission: Tom had been on Qualude, Marijuana, LSD, History in Montgomery County Home of overtly psychotic behavior and a bizare suicide attempt. He had threatened and assaulted his father.

3. Who reported behavior: Pt and Father

DIAGNOSIS: 1. Admission Note: Drug dependence

2. New Case Conference Note: Adolescent & Drug Rx accompanied by mixed drug abuse

3. Discharge and date

4. Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Tom was admitted to 4so. He was assigned to Dr. Hammer, of the adolescent service. He was transferred to Bld. 9 Sept. 29, 1972. Oct 9 he was transferred back to Bld. 4 for acting out behavior.

Oct 25 he was transferred to Bld. 9.

11/1—Tom eloped—on return was placed on 4so.

2/5—Trans to Bld 9

Attends school program, music therapy, 2 group therapies/wk. Takes Meds

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(145)

Date: 2/15/73

NAME: Hutchins, Judy

AGE ON ADMISSION: 17 BIRTHDATE: 9/20/55 Present Age: 17

COMMITMENT: 1. Date on original and present 11/27/72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Wendell

2. Reasons for Admission: bizarre behavior

3. Who reported behavior: Parents, BSU

DIAGNOSIS: 1. Admission Note: R/o Acute Schizophrenic reaction

2. New Case Conference Note: Acute schizophrenic reaction 295.4

3. Discharge and date: 295.4 2/8/73

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg 4. Rx'd with Phenothiazines; Accepted to Adolescent Service to Dr. Lustig Transferred to Bldg 9. Rx'd with milieu, family & pharmaco-therapy.

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(146)

Feb. 7, 1973

NAME: Golden, Sally

AGE ON ADMISSION: 14.8 BIRTHDATE: 4-13-58 Present Age: 14.10

COMMITMENT: 1. Date on original and present: 12-15-72

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Coin C. Lindquist, M.D.

2. Reasons for Admission: Suicide attempt, ideation.

3. Who reported behavior: Pt.

DIAGNOSIS: 1. Admission Note: 1 Psychoneurotic depression of suicidal ideation 2. Adol. Adj Rx with hysterical feature

2. New Case Conference Note:
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to #4 12.15
Transferred to # 9 12.18
Dr. Armstrong
Attended School, O.T., A.T., Gp.T., Rt. until started school full day.
Family Tx
Takes meds
No problem

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(147)
2/7/73
K.O.

NAME: Micheal King, 14.7

AGE ON ADMISSION: 14 BIRTHDATE: 7-3-58

COMMITMENT: 1. Date on original and present: 11/2/72

2. Type on original and present: 403
3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Mike stayed in his room at home for 43 days, refused O.P. help; has severe school phobia & refused to attend school

3. Who reported behavior: Mother

DIAGNOSIS: 1. Admission Note: Schizoid Personality, Severe 301.2

2. New Case Conference Note: Schizoid personality with school phobia
3. Discharge and date
4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Mike was admitted directly to the adolescent unit. He is involved in school here, and 2 group Tx a week. He is a pt of Dr. Rosen. He is cooperative on the unit, but the staff feels that his will be a long stay.

Cooperative.
Takes meds

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(148)
K.O.
3so 2-21-73

NAME: Lucas, Walter 19.3 y.o.

AGE ON ADMISSION: 17. BIRTHDATE: 10-30-53

COMMITMENT: 1. Date on original and present: 7-31-70 8-29-72

2. Type on original and present: 416 402
3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Newman

2. Reasons for Admission: Transfer for ESSH retardation, "schiz, process" Chronic brain syndrome

3. Who reported behavior: Paul Goldberg of ESSH

DIAGNOSIS: 1. Admission Note: Mental retardation with Psychosis R/o Schiz, latent type

2. New Case Conference Note: Moderate mental retardation

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

24 times in seclusion from Aug. 13, 1970 to 6-8-72

Pt on 3S—Dr. Lawrence

In the School Program on 3So

He is a behavior problem—Impulsive

---

(149)

D.B.

Date: 2/21/73

NAME: McCauley, Mary Ellen

AGE ON ADMISSION: 16 BIRTHDATE: 2/26/56 Present Age: 16.11

COMMITMENT: 1. Date on original and present 11/7/72

2. Type on original and present: 403-403

3. Changes type and when:

Admission: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Seceral & Alcohol Overdose—Temper Tantrums and rebellious behavior at home reaction of adolescence.

3. Who reported behavior: Dr. Fitti, BSU III; Parents

DIAGNOSIS: 1. Admission Note: Adjustment reaction of adolesence.

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Mary Ellen is a pt of Dr. Armstrong. She is enrolled in the school program, has group Tx 2 times a week. She has individual therapy with Mrs. Thompson.

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(150)

NAME: Mosco, Benjiman

AGE ON ADMISSION: 14yrs. BIRTHDATE: 12-20-57 (15.2 yrs.)

COMMITMENT: 1. Date on original and present: 5-15-72

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Mary P. Siegel, M.D.

2. Reasons for Admission: Behavior problem: Sexual acting out, foul language, physically abusing step-mother, running away, crashing family car, drugs.

3. Who reported behavior: Step-mother, Gandenzia Hacek

DIAGNOSIS: 1. Admission Note: 308.4, Unsocialized aggressive reaction of adolescence.

2. New Case Conference Note. Same

3. Discharge and date: 11/22/72—STL; Renewed 12/22/72

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt. admitted to closed unit on 5/15/72 and was transferred to the open unit on the Adolescent Service on

5/23/72 under the care of Dr. Hanno. Received individual & group therapy and was enrolled in the special education school program.

Family was seen in 10/72, 11/72, & 12/72 in family therapy with Family Service. (Media). Presently pt. is an STL—to be discharged as soon as father comes to hospital to sign papers.

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(151)
2/7/73
E L

NAME: Moss, Alan
AGE ON ADMISSION: 15 yrs BIRTHDATE: 3-24-57 (15.11 yrs)
COMMITMENT: 1. Date on original and present: 1-10-73
2. Type on original and present: 403
3. Changes type and when: None
ADMISSION: 1. Admitting Physician: G. P. Kratsa, MD.
2. Reasons for Admission: Depressed and suicidal
3. Who reported behavior: Patient
DIAGNOSIS: 1. Admission Note: Depressive Reaction
2. New Case Conference Note:
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Patient admitted to Closed Unit (5s) on 1-10-73 and was transferred to Bldg 9 on 1-13-73, Adolescent Service under care of Dr. Kratsa. Attended program on Unit, OT,

Art Therapy, Recreation Therapy & Group Th. Was entered into School Program Bldg 2 on 1/24/73. Family was seen 1/13/73; 1/19/73; 2/2/73 in Family Therapy. Further Neurological Studies are indicated and have been scheduled.

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(152)
K.O.
(IN) 2-21-73
NAME: Osbourne, Sue 16.4
AGE ON ADMISSION: 16 BIRTHDATE: 10-7-56
COMMITMENT: 1. Date on original and present: 1-22-73
2. Type on original and present: 403
3. Changes type and when:
ADMISSION: 1. Admitting Physician: Dr. Wicoff
2. Reasons for Admission: Taking I.V. methadrine for 2 yrs
3. Who reported behavior: Pt.
DIAGNOSIS: 1. Admission Note: Habituation —Methadrine with recent hallucinations auditory & visual
2. New Case Conference Note: Adjustment Rx of Adolesc. with drug abuse.
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt admitted to drug program—1 No.—Dr. Zal.
Involved in group therapies.

(153)
K.O.
2-21-73

(35) NAME: Parmed, David—16.8
AGE ON ADMISSION: 16 BIRTHDATE: 6-1-56

COMMITMENT: 1. Date on original and present: 6-5-72
2. Type on original and present: 403
3. Changes type and when:
ADMISSION: 1. Admitting Physician: Dr. Siegel
2. Reasons for Admission: Transfer from ESSH —Childhood Schiz.
3. Who reported behavior: ESSH—Bill Scott
DIAGNOSIS: 1. Admission Note: Childhood Schiz.
2. New Case Conference Note: Same
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)
3 So—Dr. Lawrence
In school program on 3 So
Behavior problem—Aggressive, impulsive

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(154)
2/7/73

NAME: Pollock, Michael (Nick)
AGE ON ADMISSION: 16 BIRTHDATE: 12-18-55 Present Age
COMMITMENT: 1. Date on original and present: 11-2-72

2. Type on original and present: 406
3. Changes type and when:
ADMISSION: 1. Admitting Physician: David N. Wicoff, M.D.
2. Reasons for Admission: Patient describes dissociative state while stealing a car and breaking into another. Several past suicidal attempts. Has heard voices & has had visual hallucinations. Judgment inmature impulsive. Suspiciousness
3. Who reported behavior: Patient.
DIAGNOSIS: 1. Admission Note: Border line Psychosis w/depression
Drug Habituation—LSD
2. New Case Conference Note: Schizoid personality, severe
3. Discharge and date
4. Present:
PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status.)
Institutionalized since 5 years old.
11-8-72 refused A.M. MEDS "doesn't want it"
11.14 needed additional meds for agitation.
11.16 off grounds returned by guards & nurses.
11-25 refused AM MEDS
12.6 agitated & fearful, banging hand on wall, threatening, talking of hurting himself and dying.
Transfer to Bldg 4
12.8 refused same meds
12.28 pt. reported pains in hand & wrist from agitation & hitting a window
12.28 refused meds
1.1.73 broke glass in candy machine in lobby

1.2 refused all meds

1.3 extreme agitation—put fist & arm through window—cut's

1.5 reported severe headache and difficulty breathing from "anxiety"

1.7 reported extreme depression over weekend & drug usage

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(155)

1.10 scratched arm with razor in suicidal gesture upon postponement of an appt.

1.22 stated he was "losing control"—requested meds.

1.29 reports LSD usage over weekend—upset by flashbacks—

Transfer to Bldg 4

1.30 refused AM meds

11 31 Return to Bldg 9

2.4 Pt. eloped

2.6 returned by Mrs. Iverson—laceration of left wrist, self-inflicted

To Bldg 4

2-12 Return to Bldg 9—

—Pt. asks consistantly for help but responds minimally to attempts by the staff.—

MED Feb

Prolixin 5 mgm QID

Donnatal tab + TID

Multivits + OD

Artane + mgm QID

Peotafrave 50 mgm TID [triangle] QID

Benadryl (elix) 100 mgm H.S.

Thorazine 10 mgm PRN (for Flashbacks or Hallucinations)

Mellaril 75 mgm PRN (agitation)

Calfeoget tab (headache)

Tigan 250 mgm PRN

D/C Thorazine 50 mgm Im

PROGRAM

School in bldg.—daily

Art Therapy—daily

Recreation. Therapy—daily

Group Therapy—2x weekly

Indiv. Therapy—2x weekly

Counseling (Brassell)—On Demand

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(156)

NAME: Saunders, Peggy Ann

AGE ON ADMISSION: 17 3/15/55 BIRTHDATE: 3/10/55

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: Admitting Physician: Wicoff

2. Reasons for Admission: Retarded, Brain damaged management [Illegible]

3. Who reported behavior: School

DIAGNOSIS: 1. Admission Note: Mental Retard Explosive BEHAV

2. New Case Conference Note: C 5

3. Discharge and date C 5

Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Closed Ward.

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(157)

Date: 2/15/73

NAME: Taylor, Thomas

AGE ON ADMISSION: BIRTHDATE: 5/27/58 Present Age: 14

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 403

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Gold

2. Reasons for Admission: Suicidal ideation

3. Who reported behavior: Children's Cottage

DIAGNOSIS: 1. Admission Note: Adjustment reaction of adolescence with suicidal ideation.

2. New Case Conference Note: Schizophrenia, latent type 295.5

3. Discharge and date

4. Present: 295.5

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to Bldg. 4. Assigned to Dr. Lusig. Rx'd with phenothiazine, resulting in rapid reconstitution. Transferred to Bldg 9. Eloped. Transferred back to Bldg 4.

(158)

2/7/73

NAME: Terence Thomson Present Age: 18.9

AGE ON ADMISSION: 17.4 BIRTHDATE: 3-3-54

COMMITMENT: 1. Date on original and present: 8/20/71 2/7/73

2. Type on original and present: 403 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: B. H. Armstrong, MD.

2. Reasons for Admission: Destructive to house breaking furniture; impaired judgment, pre occupation with exhibitionistic sex, threatening sexual & physical to mother.

3. Who reported behavior: Parents.

DIAGNOSIS: 1. Admission Note: Undiff. Schiz. Reaction 295.99 ~~Mental Retardation 310~~

2. New Case Conference Note: Passive—aggressive personality. Mental retardation, Mild. Ampathy [Illegible]

3. Discharge and date

4. Present: Same

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted by Dr. Armstrong. On Adolescent Program, School Program, group therapy, family counseling. Cooperative, friendly, gets along with peers, and staff. Very inactive, even babyish when with his parents. Pt. has done well in school, adjusted well to Adolesc. program. Goals include getting into some sort of job training (eg. Bakery), later get job, live at home. Needs to be

communicative, responsible, grown-up in relationship with his parents.

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(159)
K.O.
2-21-73

NAME: Vantine, Michael 16. OY.O.

AGE ON ADMISSION: 15 y.o. BIRTHDATE: 2-7-57

COMMITMENT: 1. Date on original and present: 8-24-72

2. Type on original and present: 403

3. Changes type and when: None

ADMISSION: 1. Admitting Physician: Dr. Armstrong

2. Reasons for Admission: Transfer from Friends Hospital due to lack of funds; history of barbiturate dependency, seizures. Suicidal attempt 6 wks prior to admission.

3. Who reported behavior: Child case worker

DIAGNOSIS: 1. Admission Note: Schiz, latent type; adjustment Rx of adolesence with depression; minimal cerebellar dysfunction

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

9-18-72—cut arm, not seriously

11-8-72—suspected of selling drugs at school

11-13-72—attempted to hang himself

12-11-72—stole medications fr 9So medication cabinet

12-11-72—possible drug overdose

12-26-72—drinking, & found with pills in his possession

Dr. Hammer's pt. when not in Bld 9 he is a pt of 4so

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(160)
February 21, 1973

NAME Graber, James

AGE ON ADMISSION: 17 BIRTHDATE: 4/26/55

Present Age: 17 yrs.

COMMITMENT: 1. Date on original and present: 2/2/73

2. Type on original and present: 405-403

3. Changes type and when: Changed to 403 on 2/7/73

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Valium Overdose, suicidal ideations, assaultive behavior in the home.

3. Who reported behavior: Mrs. Virginia Owen (Child case worker) Father Francis Serick (Principal of Msr. Bonner H. S.)

DIAGNOSIS: 1. Admission Note: Depressive Reaction.

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt. evaluated & accepted by adolescent Service. Transferred to open building 2/2/73 under care of Dr. Gus Kratsa. Eloped 2/13/73. Current on U.A.

(161)
Date: 2/14/73

NAME: Anita Jenkins

AGE ON ADMISSION: 16 BIRTHDATE: Present Age:

COMMITMENT: 1. Date on original and present: 405—11/29/72

2. Type on original and present: 405—408 12/5/72

3. Changes type and when: 405—408

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: charges of assault & battery while at Sleighten Farm.

3. Who reported behavior: Sleighten Farm

DIAGNOSIS: 1. Admission Note: 1. Mild Mental Retardation 2. Antisocial personality

2. New Case Conference Note: Unsocialized aggresgressive vxn of adolescence

3. Dicharge and date

4. Present: Unsocialized aggressive vxn of adolescence

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Admitted to 5N—Dr. Wojcrechosk

Acute Treatment Unit—I.C.U.

Program: individual therapy, school tutoring, group therapy (5N), remotivation group, occupational therapy

Current status—controllable aggressive tendencies,, but tends to be provocative with vulnerable, Individual She attends school and group, but is easily discouraged and feels worthless. She goes weekly for weekend visits at home.

(162)
K.O.
2-22-73

NAME: Rhinehart, David 16.4 y.o

AGE ON ADMISSION: 16yo BIRTHDATE: 10-3-56

COMMITMENT: 1. Date on original and present: 1-11-73

2. Type on original and present: 408

3. Changes type and when:

ADMISSION: 1. Admitting Physician: Dr. Wicoff

2. Reasons for Admission: Court—Stealing cars

3. Who reported behavior: Parents

DIAGNOSIS: 1. Admission Note: Deferred

2. New Case Conference Note: Non psychotic organic brain syndrome antisocial personality

3. Discharge and date

4. Present:

PROGRSS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

David had been in the adolescent service under Dr. Kratsa's care in the Closed Unit. He was transferred to the open unit. While there he stole a car. He was transferred to the Closed Unit again. ~~He has since had a Court hearing at which time~~

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(163)
K.O.
2-22-73

4N

NAME: Schriber, Elizabeth 14.3

AGE ON ADMISSION: 14 BIRTHDATE: 11-25-58

COMMITMENT: 1. Date on original and present: 1-25-73

2. Type on original and present: 408

3. Changes type and when: extended indefinitely 2-4-73

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reasons for Admission: 10 day evaluation at request of court

3. Who reported behavior:

DIAGNOSIS: 1. Admission Note: Adjustment Rx of Adolescence; suicide attempt and ideation

2. New Case Conference Note:

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Pt is on 4No, Adolescence service. Dr. Kratsa is her doctor. She is enrolled in VAS.

She will be transferred from the Closed unit to the Open unit shortly.

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(164)

K.O.

2-23-73

(4S)

NAME: Willett, Steve, 16.9 yo

AGE ON ADMISSION: 16 BIRTHDATE: 4-26-56

COMMITMENT: 1. Date on original and present: 1-23-73

2. Type on original and present: 408

3. Changes type and when: Extention on 2-2-73 for 30 days per Judge Reed

ADMISSION: 1. Admitting Physician: Dr. Wic-off

2. Reasons for Admission: Violation of probation

3. Who reported behavior: Judge Reed (?)

DIAGNOSIS: 1. Admission Note: Runaway rx of adolescence (?)

2. New Case Conference Note: Adolescent adjust-ment rx

R/o Drug dependence

3. Discharge and date

4. Present:

PROGRESS: (Very brief summary of hospital course: where admitted, doctor, what program, current status)

Steve is a pt of Dr. Kratsa on 4So.

Adolescent service, locked building.

Court hearing 2-21-73—recommendation to be sent to St. Gabriel.

(165)

EXHIBIT C

HAVERFORD STATE
LEVINE, Leslie
9645 1

SUMMARY

This is the first Haverford State Hospital admission for this 15 year old, white, single, 10th grade student admitted here 10-11-72 on a 403 commitment signed by her mother. The patient's mother and her two sisters were seen along with the patient by Dr. Arenowitz at Base Service Unit III for 9 sessions during the months prior to admission because of family quarrels. On the day of admission the patient felt as she stated "closed in" by the mother and she threatened the mother with a kitchen knife. The mother contacted Dr. Arenowitz who recommended hospitalization at Haverford State Hospital.

The patient's parents have been separated since the patient was approximately 5 years of age. Patient did not see her father again until March, 1971. During the past 2 school years Leslie and her mother have had battles over everything Leslie has wanted to do. Subsequently, Leslie began having problems in school. In an effort to help her finish the school year she was sent to Florida from March to June, 1971, and February to June, 1972, to live with her father and step-mother and complete the school year. Leslie idolizes her father although the period spent with him and her step-mother were not idealic because of the step-mother making her do domestic duties.

On admission here the patient was admitted to a closed ward and evaluated by the Adolescent Service on

October 12, 1972. She was than transferred to the open adolescent building where she remained until discharge. She was placed on Stelazine 2 mgs. tid until November 13th when psychiatric medications were discontinued. While on the open ward she participated in group therapy twice a week, was assigned a counselor and seen individually by either Dr. Armstrong or Dr. Rosen as was needed. She also attended school regularly. She and the family were seen by Dr. Lustig on a regular basis in Family Psychotherapy.

New Case Conference held on October 16, 1972, revealed a diagnosis of Adolescent Adjustment Reaction. Psychological testing revealed a 15 year old girl functioning within the average range of intelligence with indications that her poor school achievement had been due to basic difficulty in handling specific facts. She revealed a tendency to overlook details. She seen as a highly infantile individual who responded hostily to the environment and who used all her resources to contain her negative feelings. It was felt that at times of stress, particularly when related to quarrels with her mother, acting out behavior was highly likely.

Electroencephalogram, neurological and routine lab studies were all normal. Routine physical examination was normal.

(166)

On the open ward patient remained rather withdrawn, socializing minimally with the patients and staff. If an incident occurred, she seemed always to be present but denied any active participation in the scene. Finally towards the second week in October she became involved with another patient in a number of incidents in which

she broke minor rules on the floor, became verbally abusive, began to tease another patient and she was transferred to the closed unit on October 18th. On the closed ward she soon settled down, attending school and was given limited ground privileges. She was transferred back to the open ward on October 23rd where she remained on no medication until her discharge. Both the patient and her mother wish the patient to live with her father in Florida and complete the school year as done in the past. Both agreed to our recommendation of individual therapy while living with the father in Florida. Because of the chaotic family situation in Florida discharge had to be delayed until its resolution. When this was done the patient was discharged on 11-16-72.

DIAGNOSIS: Adolescent adjustment reaction.

RECOMMENDATIONS: Patient to live with father in Florida and continue out-patient and individual therapy in Florida.

Howard Rosen, M.D.

HR/dmn/1s

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(167)

HAVERFORD STATE HOSPITAL
WEAND, Mark

SUMMARY:

PSYCHIATRIC HISTORY:

This 15 year old white boy was admitted to HSH on 6-24-72 under a 402 commitment following transfer from Osteopathic Hospital where he had remained overnight. His admission there was precipitated by ingestion of approximately 8 Valium and possible glue sniffing. While

under the influence of drugs the patient tried to kill his uncle with a knife. At the time of his admission to HSH he was still intoxicated from the use of drugs and was extremely hostile; at that time it was not possible to perform an adequate mental status examination. Subsequent mental status the following day revealed the patient to be oriented in all spheres and to exhibit no evidence of psychosis. However marked impulsivity and immature judgment were present.

Past psychiatric history included the patient having been placed on probation after a drug abuse charge and a court evaluation on February 20, 1972. Mark has a 1½ year history of underacheiving, truancy and drug abuse.

Psychological Evaluation was done by the court on February 20, 1972 and revealed a full scale I.Q. of 82 (the dull normal range of intelligence.) It was noted that he had impaired concept formation.

His parents were divorced in 1960. His mother lives with an unmarried brother and sister and the maternal grandmother. Mark has a 17 year old sister.

New Case Conference was held on July 3, 1972; diagnosis at that time was 309.14 Non-psychotic organic brain syndrome, Valium and others, and 306.4 Unsocialized aggressive reaction of adolescence.

During the month of July the patient was seen by Dr. Rashkis in group therapy twice per week. On 7-12-72 he was transferred to Adolescent Service Open Unit. He received no medication other than Benedryl 100 mgmh.s. Subsequent laboratory tests, EEG and Neurological Examination were all within normal limits. On the open unit the patient attended group therapy twice a week and was seen individually once a week by Dr. Armstrong.

After approximately 3 weeks it was decided in Staff Conference that the patient's family should be seen in family therapy. This was begun in early August on a once a week basis. The patient's aunt, uncle and mother were included in most sessions. In one session the sister came, (168) and in one other session the maternal grandmother came.

Due to complaining of being depressed the patient was placed on Tofranil 25 mgm t.i.d. for 3 days then Tofranil 50 mgm t.i.d.. Tofranil was discontinued on 8-21-72 with no effect at that time. Patient was placed on Elavil 25 mgm t.i.d. for 3 days and then Elavil 50 mgm t.i.d.. On 8-10-72 the patient was transferred to 5 South Adolescent Service Closed Unit due to his having taken 3 Tuinal and having sustained an unsteady gait, slurred speech and uncontrolled behavior while in the open building. He was transferred back to the Adolescent Service Open Building on 8-14-72. The patient continued to state that he felt he was being kept in the hospital against his will and he denied that there was any problem other than his drug usage. However it was apparent from his behavior toward the staff and other patients, that there is marked passive-aggressiveness and disproportionate hostility and suspicion in dealing with others. The patient was considered appropriate for the Adolescent Program because of his personality problems, the drug abuse was judged by the staff to be symptomatic of these problems. It was the best judgment of the Adolescent Service physician that a drug treatment program per se was not the treatment choice, but the more appropriate modality was that of a milieu group. On Labor Day weekend the patient was given a weekend pass and he was given sufficient Elavil for 3 dosages a day for 4 days. He took the entire dose at one time and arrived in a comatose state back at

this hospital; he was transferred to Bryn Mawr Hospital and remained in the Intensive Care Unit for 24 hours before being transferred to the closed unit in Adolescent Therapy. Patient continued to be very angry, sullen and unreachable.

Family Therapy was continued with varying numbers of the family present. Patient continued in the Special Education School Program. He also continued in group therapy twice per week. Following the overdose of medication patient was placed on no medication with the exception of the small amount of Thorazine for agitation 25 mgm which was continued for 7 days and than discontinued. In October, family therapy consisted of the patient and his mother only, this was an attempt to allow them to break away from the mother's primary family and to live in an apartment. The patient was placed on Short Term Leave on 10-18-72. He was to become involved in out-patient therapy prior to discharge. On 10-24-72 the patient was brought back to the Adolescent Service by the police after being questioned due to false accusation of stealing. He also appeared to be on drugs and was requested to give a urine sample which he refused. He (169) then superficially slashed his wrist and was readmitted to the closed building. He was transferred back to the Adolescent Service Open Unit on 10-26-72. He was again placed on Short Term Leave on 11-1-72 with the understanding that he become actively involved in out-patient psychotherapy at B.S.U. II and to continue in HSH Special Education Program. He was on no psychiatric medication. In all, patient was seen in group therapy 28 times, family therapy 8 times and individual therapy 7 times.

BHA/dmn

Barbara H. Armstrong, M.D.

(170)

HAVERFORD STATE
GENTILE, Stephen
7100

SUMMARY

This 18 year old, white male has been a patient since August 24, 1971, when he was admitted under Section 403 (signed by parents) for his having become violent and aggressive towards his family and younger children in his neighborhood. A previous hospitalization from 12-29-70 to 4-21-71 terminated when patient was discharged against medical advice from unauthorized absence. His diagnosis at that time was—Schizophrenic Reaction, chronic undifferentiated type. At the time of admission and subsequently the patient presented with confusion, disorientation, inappropriate affect, often giggling without apparent cause, ideas of reference, unprovoked aggressive acts toward Staff and considerable degree of hostility in the form of restlessness and agitation.

Chemotherapy and a course of ECT from September-October 1971, had only marginal involvement for the patient. This examiner assumed management of Stephen's case starting in January of 1972. More reality contact and less confusion was noted in March and medication was readjusted. Patient was extremely resistant to being transferred to the open unit of the Adolescent Service. He frequently refused structure and support. The Adolescent Staff was able to maintain him in the open unit from May through continual support but only with some difficulty. Patient became confused, was involved in antisocial acting-out and fecal smearing, and was transferred to a closed unit from August 4 to October 9, 1972. He returned to the open unit after he became better able to

handle a less structured environment and after he stabilized on phenothiazines.

Since his return to the open unit, patient has been in a modified school program, receiving chemotherapy and family therapy on a weekly basis. His weekends home from Haverford State Hospital have been uneventful, although parents report patient has difficulty in socialization, stays close to the family and is uneasy when in public.

Plans are for gradual increase in patient's school program and reduction of medication to an out-patient maintenance level before discharge. The patient has required high doses of medication in order to be able to function and his improvement has been marginal until now. He is still considered incompetent, appearing confused as to his goals, lacking any insight and judgment as to his reasons for hospitalization.

Diagnosis:— Schizophrenia, chronic undifferentiated type.

Currently, the patient is placed on the following medications:— Artane 1 mg. bid, Benadryl 100 mgs. hs and Thorazine 300 mgs. qid. He has been scheduled for group therapy twice per week and individual therapy once per week. Patient has attended group therapy 33 times, Individual Therapy 16 times and Family Therapy 12 times.
CH/ frg

11/28/72

Carl Hammer, M.D.

(171)

HAVERFORD STATE
MATHEWS, Vicki
9416

SUMMARY

Psychiatric History

This is the first Haverford State Hospital admission for this 15 year old, white, 9th grade student, admitted to this hospital 8-9-72 on a 403 commitment, signed by her parents. She was brought to the hospital by the police for psychiatric evaluation with the approval of the Assistant Superintendent Dr. Phillips, after being picked up in the park in an incoherent, assaultive state along with several young men. Patient had run away from home approximately 10 days prior to admission.

The patient and her family had been seen for family psychotherapy in the Irving Schwartz Institute in 1971 and the Philadelphia Child Guidance Clinic in 1972. Family terminated both these contacts on their own because they sought individual psychotherapy for her with Dr. Curran. After several sessions the latter left for vacation. The family stated that Dr. Curran's advice was to let Vicki live away from home and check in with them periodically. She subsequently ran away and they had no contact with her other than occasionally by telephone until summoned by the police on August 9th, as noted above.

The patient has failed and repeated the 7th grade. The family states that she has a reputation as the "school tramp" and that her siblings are embarrassed by her behavior. She has been picked up by the police on several occasions although no charges were pressed. On one occasion last year she ran away to Elkton, Maryland and stayed away overnight on several other occasions. At age 3 years, Vicki was evaluated at the University of Pennsylvania for stammering. In the second grade the parents and the child were seen by Dr. Herman Staples when Vicki refused to go to school.

On initial status patient appeared as a small adolescent, oriented fully and unsteady of gait. There was much evidence of anger and hostility. She admitted trying to commit suicide while in jail (multiple scratches on both wrists and arms)—"What do I have to live for—a bunch of shit!" She admits to having abused drugs for 6 to 7 months (Quaalude and Tuinal) and said that she had 2 Tuinals that morning. Prior to this she smoked hashish and marijuana. She vented much hostility towards her family, particularly her father, "My family is screwed up. What can I do? I tried running away and it just got me in jail." In addition, the patient told her father that she had been raped the night before.

(172)

Psychological testing was done and compared to the report from the Irving Schwartz Institute (which the family was very reluctant to release to us). Based on this report, there was no evidence of a thought disorder. The patient was currently functioning on a lower average range of intelligence, giving evidence of bright, normal and even superior learning capacities, only partially utilized at the time of testing. (Negative attitudes toward school and clear deficit in school related tasks suggest this area as the focal point of much of her current difficulties.) In general, she was seen as a frightened girl, who was attempting to strike out at her surroundings in self defense.

Social Service workers' impression was that the parents have been seeking professional help since she was 3 years old. The family has been extremely critical of past professional psychiatric help and they see Vicki's problem as an individual one and not as one of the family or between the marital partners. They are very eager for placement outside of the home.

Hospital Course

Progress in the hospital.

The patient was admitted to a closed facility. For the first 48 hours she required psychotropic medication and confinement in order to help her to control herself. She remained unsteady of gait and verbally abusive. Within a few days, however, she settled down and received ground privileges.

On August 9, 1972 she claimed to have been struck by another patient while making a telephone call. She eloped from the hospital that weekend. On August 23, 1972 she was transferred to the open adolescent facility and on August 25, 1972 the family was seen to preliminarily sound them out on future planning. Mrs. Mathews, in particular, did not desire Vicki to return home. The preliminary recommendations of the Adolescent Service were conveyed to the family in that the patient needed a structured, residential school setting and should not return to the family.

Meanwhile, the patient continued on no medication; she attended group therapy on a twice a week basis; she was assigned to an individual counsellor, and was seen individually by either Dr. Rosen or Dr. Armstrong, as required.

(173)

On September 5th, the patient became increasingly agitated. She refused to go to school, which was starting that week and was quite obviously concerned about disposition. The agitation increased with a number of incidents on the ward, including threatening to elope and smoke pot so that ultimately the patient was transferred back to a closed ward on September 12, 1972. She remained there for approximately 3 days and soon calmed down and she was able to attend school from the closed building on grounds privileges, and then was returned to the open unit on September 15.

At Staff Conference in mid-September two recommendations were made—one for residential schooling, since it seemed desirable to remove the patient from the family setting because the family had been so rejecting of her and scapegoating her. In view of the patient's apparent willingness for residential placement, and necessary financial resources, a school such as Devereaux, which is a residential treatment center, was recommended to them. Secondly, if the patient's financial resources would not permit private residential placement, it was recommended that the family take the patient to court to be declared incorrigible. Three, the patient was not considered suitable for public school education because of the long history of emotional disturbance.

The patient was informed of the Adolescent Service's recommendations and the family was again consulted. Interviews were arranged at Devereaux for the family and the patient. The patient also made application to the George Junior Republic School in New York State.

On the ward the patient was started on Haldol 1 mg. tid. and Cogentin 1 mg. tid. The patient continued to

attend group and school uneventfully until the second week in October. At that time she became anxious and refused to attend certain assigned activities and became verbally abusive, breaking minor restrictions on the ward, especially harassing other patients. An attempt was made to deal with this on the open ward administratively but this failed and the patient had to be transferred to the closed ward again on 10-18-72. She remained there only a couple of days and saw that she was inappropriate in how she had acted. She was transferred back to the open ward 10-20-72 where she remained until her discharge on 11-7-72.

On admission, physical exam was unremarkable. Neurological exam was normal. EEG and routine admission studies were normal. GYN consult dated August 14, revealed no signs of forced sexual intercourse (see history —patient denied having intercourse as stated to father). Marital introitus.

(174)

Patient sustained a lower urinary tract infection and was treated with penicillin.

Her medication at time of discharge was Cogentin 1 mg. tid. and Haldol 1 mg. tid.

Diagnosis: Passive aggressive personality, aggressive type 301.81

Disposition: Discharge 11-7-72 to the parents for transfer to the Devereaux School.

HBR/em

Howard B. Rosen, M.D.

(175)

HAVERFORD STATE
BARTLEY, Kevin
8369 1

SUMMARY

This 16 year old male has been a patient since November, 1971 when he was admitted on a 403 commitment signed by his mother, as a transfer from Eastern State School and Hospital. He had been at Eastern State School and Hospital since January 11, 1968 with a diagnosis of organic brain syndrome with Epilepsy and Explosive Personality Disorder. He was transferred to the open unit of the adolescent service and came under this examiners supervision in January, 1972. He has continued to be hyper-sensitive to rejection from family and staff and often acts aggressively when depressed. Since the loss of his father, this patient has had many self doubts and low self esteem and has known to be accident prone and self destructive. With support and working with a therapeutic milieu of staff the patient has made considerable progress in recent months. He continues to require anti-convulsive medication and his seizures have been under control during his hospital stay. This patient has been known to interact with the staff and other patients in an aggressive way often asking to be hurt and punished. When self destructiveness or aggressiveness toward the staff became uncontrollable, the patient has required transfer to a closed unit for self protection or for protection of others. He generally responded well to these temporary restrictions and has not required extended use of the closed unit. At the present time the patient is living with his mother and siblings.

Since April, 1972, many referrals have been made toward finding a suitable school-vocational program in the community. Because of his being multi-handicapped with an organic seizure disorder and his emotional lability in the past, he had not been accepted. Efforts to work with his mother to allow her to become more receptive to his return to his home and community have been difficult, but have also improved considerably in recent months.

The patient was evaluated 11-20-72 by Elwyn for consideration for their school work program and it appears he may start there in the near future. Since 11-22-72, he has been on short term leave. Delays in finding transportation to our Special Education Program at Haverford State Hospital finally are being worked out.

Diagnostically, he remains 1) Organic Brain Syndrome with Epilepsy and 2) Personality Trait Disturbance, explosive type with depressive features. Tests have indicated his ability to work in a school vocational program and it is anticipated he will be discharged to Base Service Unit for follow-up care and controlled by chemotherapy once he has begun this program.

(176) Patient was placed on the following medications: Phenobarbital gr. 1 tid, Dilantin 100 mgs. tid and Valium 5 mgs. qid and Benadryl 150 mgs. hs plus 1 green placebo.

Patient has been scheduled for group therapy twice per week during his hospital stay. In all patient was in group therapy 42 times. Since January, 1972, he has been seen individually by Dr. Hammer in an approximate once per week basis. Actual attended sessions number 16 times.

1s Carl Hammer, M.D.

Philadelphia, Pennsylvania

May 10, 1973

HEARING

Before:

Honorable John Gibbons, J., Circuit Court Judge.

Honorable Thomas A. Masterson, J., District Court Judge.

Honorable Raymond J. Broderick, J., District Court Judge.

Appearances:

David Ferleger, Esq., Stanley Abramson, Esq., Ronald Soskin, Esq., 121 South 18th Street, Philadelphia, Pennsylvania 19103, Attorneys for Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Department of Justice, Room 323, Health & Welfare Building, Harrisburg, Pennsylvania 17120, Attorney for Defendants.

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(3) JUDGE GIBBONS: May we have the appearances?

MR. FERLEGER: My name is David Ferleger, attorney for the plaintiffs Your Honor.

MR. ROTH: My name is Barry Roth, attorney for the defendants.

JUDGE MASTERSON: Are you a Deputy Attorney General?

MR. ROTH: Assistant Attorney General.

JUDGE MASTERSON: You are an Assistant Attorney General?

MR. ROTH: Yes, Your Honor.

MR. FERLEGER: Your Honor, this is Stanley Abramson, who is going to be a graduate from Rutgers Law School and this is Ronald Soskin, who will be a graduate from Pennsylvania Law School.

JUDGE MASTERSON: We have reviewed the papers in this case. Let me ask this general question: Does the promulgation of the regulations effective May 1st with respect to children 13 to 15 cure the problem as far as the plaintiffs are concerned as to that group of children?

MR. FERLEGER: No, Your Honor.

JUDGE MASTERSON: Why not?

(4) MR. FERLEGER: The reason being that the —on two grounds. From a due process point of view the regulations allow children to be brought into an institution and deprived of their liberties solely by reason of examinations of doctors. That is in a non-emergency situation.

JUDGE MASTERSON: That can be done in the Mental Health Act as to adults on the certification of two doctors. You or I, or anybody else can be dumped in for ten days or something like that.

MR. FERLEGER: In 1971 in the Dixon case, a three Judge court in the Western District ruled that section of the Mental Health Act unconstitutional. It can't be done any more.

JUDGE MASTERSON: What do they do now?

MR. FERLEGER: Right now the only way an adult can be brought into a hospital against his will, aside from the emergency situation, is by Court commitment.

JUDGE MASTERSON: What happens in the emergency situation?

MR. FERLEGER: In the emergency situation when somebody is dangerous to himself or to other people, in that situation the County Mental Health (5) Administrator can authorize commitment for the purposes of observation and protection.

JUDGE MASTERSON: It just can't be on the certification of the two doctors?

MR. FERLEGER: No.

JUDGE GIBBONS: But it can be on the certification of the County Mental Health Administrator?

MR. FERLEGER: In an emergency situation.

JUDGE GIBBONS: How does that add to the due process? Suppose the same thing were applicable to children?

MR. FERLEGER: If the situation was dangerousness, in that emergency situation I don't have any problem with children being brought in under that emergency section which is Section 405 of the Mental Health Act.

In the non-emergency situation it is improper now to deprive adults of their liberty without a hearing, and I think also it would be improper to deprive the children.

JUDGE GIBBONS: I am afraid that is a little bit simplistic. A child say of 6 years old who is taken to a pedi-

atric ward with an emergency (6) is deprived of his liberty, and yet if you ask the child did he want to go to the hospital, in 99 cases out of 100 he would object.

It seems to me we can't look at it quite as simplistically, the due process point. It is more involved.

MR. FERLEGER: Well, at first Your Honor I was responding to the Judge's question about children 13 and older under the regulations.

In response to your comment I think it is a little bit different when it is deprivation of liberty, which means institutionalization in an institution for mental health treatment. There are a number of cases which I have cited, one being Heryford v Parker which involved a 9 year old.

In that case the Court held that when this 9 year old feeble-minded child was to be committed to live at an institution for a period of time, not to have a broken arm fixed, but to live in an institution, that a Guardian Ad Litem had to be appointed.

JUDGE GIBBONS: It may be that a guardian procedure at some point would be appropriate and even necessary, but my difficulty with approaching (7) this solely from a due process standpoint is that a suicidal child is just as much in need of emergency medical attention as is a child with a broken arm. If you surround the treatment of potentially self-destructive mental illness with so many due process safeguards you may, particularly with respect to lower income people, build in a tendency not to resort to treatment. There seems to me to be a good deal more involved here than the due process problem.

MR. FERLEGER: I agree completely with what you said for the suicidal child who acts out in a way that is self-destructive. That situation, I think, clearly is the kind of thing that presently can be dealt with through the emergency procedure. There is no problem at all, I don't think, in any county in Pennsylvania with a parent bringing in a child who is going to kill himself. The problem is, for example at Haverford State Hospital, the majority of children are brought there not for the kind of behaviors which are delinquent, stealing and running away from home. For that kind of thing there is no emergency.

JUDGE GIBBONS: You may be able to (8) establish that. We can't accept that as the fact.

MR. FERLEGER: I understand that.

JUDGE GIBBONS: But no matter whether even if that is true the process of getting the child to the hospital, keeping in mind that presumptively until 18 the parent has a firm obligation to do so, can't be made so difficult that we would be defeating the purpose of the hospitals.

JUDGE MASTERSON: It seems to me that the problem is having a procedure for someone independent of the parent and the child to review the facts concerning the child's institutionalization. I don't think that that review should occur before the institutionalization, because I agree with Judge Gibbons that that may have a deterrent effect on people having their children institutionalized when they need to be. And it seems to me that due process, meaningful due process, is served if the procedure is available so that the unwilling child can have an independent person review the facts with respect to his institutionalization, and that's why my own preliminary is that the

May 1st regulations pretty much take the steam out of your case as to the 13 to 18 year olds.

(9) MR. FERLEGER: There have been very few cases. due process cases involving the mental health of minors. There have been a large number of cases which are cited throughout the papers submitted involving due process for adults. Those cases make it clear that for adults, adults can't be deprived of their liberty without all kinds of procedural protections. The Wisconsin three Judge court in Lessard v Schmidt just narrowed down commitment to adults to dangerousness in any case. Cases involving the commitment of juveniles have mainly been of the Gault type, cases which involve committing the juvenile to rehabilitate or treat the child to help cure behavior or in some cases to cure mental problems. When those cases have examined the situation they have said that the fact that parents or somebody else wants the kid in an institution, even for his own benefit, doesn't mean that due process doesn't have to be provided.

JUDGE MASTERSON: I think that there is a point at which the natural right of parents and the extremes of due process collide. I suppose technically you could argue, with just as much force, that I ought not to be able to spank a child, maybe I (10) shouldn't, until I go before a Magistrate and convict the child of errant behavior.

Now I think you can put these things under much too fine a microscope, and I am concerned about what I consider to be meaningful deprivations. I don't think it is terribly meaningful, it doesn't upset me much, that a parent can commit a child to a mental institution and the child may be there for three or four days against its will before an independent person reviews the circumstances

of their commitment. It really doesn't bother me that much that there may be that amount of deprivation because I think that the arguments for giving the parents the right to make the initial decision are, for me, very persuasive. I don't know how my brethren feel about that.

JUDGE GIBBONS: Another thing that disturbs me about this, about your case, it presumes that the hospital is in an adverse relationship to the child, or at least it presumes in the relief it requests that the hospital should be put in an adversary relationship with the child.

Now in the Gault situation that is clearly the case, although the original theory was otherwise, (11) it has quite clearly become the case that the child is being incarcerated for criminal behavior, and that the societal control is adversary. I don't think we can make the same assumption about the hospital.

You see we are dealing with infants, the parents have a parental responsibility. The State, at least during minority, also has a parent patriary responsibility, which it may be discharging through the hospital, and when you say a due process requirement you are assuming that the hospital can not accord due process; that it can not discharge the State's nonadversary responsibility.

After all, the hospital is, if anything, a potential adversary of the parent rather than the child.

MR. FERLEGER: Your Honor, the parents patriae concept is involved, and there is more than one case which says that in the case of admitting juveniles, parents patriae means that you have to provide due process which included in that case court type process.

In terms of the hospital being an adversary, I don't feel that the hospital is an adversary. (12) I feel that the hospital is sincere in its attempt to treat the children. However, the concept of physicians, of doctors, deciding whether deprivation of liberty is appropriate is the very thing that was rejected in the Dixon case as is the very thing that has been rejected—

JUDGE GIBBONS: That is a different situation.

JUDGE MASTERSON: In any event, I would agree that you can't give the doctors unreviewable authority, but it seems to me that it is cured once you establish a procedure where the doctor's decision is independently reviewed by someone who has responsibility to no one other than the child.

I think one of the things we would all like to know, what are the facts here?

JUDGE BRODERICK: May I ask a question along those lines?

JUDGE MASTERSON: Yes.

JUDGE BRODERICK: Mr. Ferleger, I have been concerned about your second statement here this morning, and that was in response to, I think, Judge Masterson's question to you as to whether or not these regulations that were recently enacted (13) didn't take care of the situation. And you said you were primarily, or words to that effect, concerned with what, I will use the term I don't think you did, the delinquent child. Not the child that needs emergency treatment for mental or an emotional disorder, but the delinquent child. And I have a problem trying to figure out how that delinquent child would get

into the State mental hospital such as Haverford. Can you answer that for me?

MR. FERLEGER: I will be glad to Your Honor.

JUDGE BRODERICK: How do they get in there?

MR. FERLEGER: First let me preface that by giving the factual basis which isn't before the Court, but it will take a sentence to mention it.

There is a study that is being done at Haverford by the Research Department, a computerized study of hundreds of adolescents admitted during a four year period, and they have computed the types of behaviors that bring kids into the hospital. I have just glanced at it briefly, and 20 or 30 per cent, I am not sure of the exact numbers, came in because of stealing.

(14) Now the reason is, to answer your question specifically, that kids do a lot of things that to juvenile court judges, and to the delinquency laws, look like delinquent type things, and to a psychiatrist are psychiatric symptoms of a mental problem. And for those kinds of things the parents very often have the alternative. They can go through the juvenile court process, or they can go through the hospital.

JUDGE BRODERICK: That's the one question I wanted to ask you.

JUDGE MASTERSON: Let me ask this.

JUDGE BRODERICK: Yes.

JUDGE MASTERSON: Do you want to deprive the parents of going the hospital route rather than the Juvenile Court?

MR. FERLEGER: No. I have no problem with the parents going the hospital route, but I think that just as in a juvenile court process the Judge makes the determination about whether or not the child is delinquent, so the mental health process Judge should decide whether or not the person is mentally ill.

JUDGE MASTERSON: So the Judges will have (15) to be reviewing all of these commitments of adolescents to State mental institutions?

MR. FERLEGER: Judges review all involuntary commitments of adults and I feel it would be proper to also review the commitments of juveniles.

JUDGE MASTERSON: I don't think they review all the involuntary commitments of adults unless a petition is filed.

MR. FERLEGER: But if there isn't a petition filed there can't be an involuntary commitment at all.

JUDGE BRODERICK: Do you know whether someone can get into the Haverford State Hospital as a delinquent without being sent there by the Court Mr. Roth?

MR. ROTH: Your Honor, I am not apprised of that. I would assume that the person would have to be sent there by the Court.

JUDGE BRODERICK: I have always been under that impression and I didn't know, and I am not saying that it is a good idea if a parent wants to avoid the juvenile legal machinery, but I had always been under the impression that a parent couldn't voluntarily go out and say, "Look, I have a bad boy (16) here and I want you to take him in." I didn't think it worked that way.

MR. FERLEGER: Your Honor, an affidavit that we filed with the Court involves a boy who was on probation from Juvenile Court for truancy before he came to the hospital, and in his affidavit he explains that the doctor at the hospital wanted him to go to reform school, and it was made clear to him that he had a choice; to be deprived of his liberty in the mental hospital, or in reform school. And the behaviors are identical. It is just that a doctor puts a psychiatric diagnosis—

JUDGE BRODERICK: That is his affidavit.

JUDGE GIBBONS: Let's assume we take that as true, and take that there are such cases. Your position is that in no case should the juvenile be committed without a judicial proceeding. Let's assume that he—

JUDGE BRODERICK: He has an exception on that.

JUDGE GIBBONS: Except in the emergency, but that would be a short term commitment.

MR. FERLEGER: Your Honor, or in the voluntary situation. There are—

(17) JUDGE GIBBONS: Now let's take the voluntary situation by way of contrast.

How competent is a juvenile of 13 to make a decision to commit himself voluntarily? That is first.

Second, if we are talking about a judicial proceeding, do we have grounds, at least so far, for laying down a rule that the Guardian Ad Litem in that proceeding may not be the parent, which in effect, it seems to me that is going to have to be your position, that in every instance you are going to convert the commitment proceeding into an adver-

sarial proceeding between a Guardian Ad Litem, because the juvenile can't appear otherwise, and the parent.

MR. FERLEGER: Heryford v. Parker involved a situation where the 9 year old, according to the Court, was entitled to a Guardian Ad Litem other than the parent. In terms of the voluntariness of a 13 year old in that capability, there are situations at Haverford Hospital, as a deposition that has just been transcribed will indicate to you, where children are in the hospital and where the hospital thinks they should remain but the parent (18) who signed them in now decides to take them out, and under the law now, the situation where a hospital thinks a child should be there and the parent wants the child out, in that situation the parent can, and does, take the child out.

JUDGE GIBBONS: The State has a remedy. There are other statutes governing that situation. They can terminate parental rights. There are other steps that can be taken.

MR. FERLEGER: Or they can have the regular Section 406 civil commitment.

JUDGE GIBBONS: I am not concerned with that case because assuming that the hospital is acting for the child there are ample—

MR. FERLEGER: But there are other cases Your Honor, like one which I know where the child wants help, the child would love to sign into the hospital because the child is afraid of killing herself in this case, but the parents don't want to sign the papers. And in that situation you are telling the child that you have to run around to welfare agencies, or to the State authorities in order to get in.

JUDGE MASTERSON: How would we handle (19) that?

MR. FERLEGER: The way it can be handled Your Honor is by permitting any person to apply for voluntary care in the hospital.

JUDGE MASTERSON: Regardless of age?

MR. FERLEGER: Right. The hospital would then make their evaluation of the need, and if there was a need for commitment then a person could stay, even if the parent decided that the child didn't need help.

You see, there is—

JUDGE GIBBONS: Of course you are going far afield. You can't contend that the inability of a juvenile to commit himself voluntarily is a due process violation.

MR. FERLEGER: That is an equal protection issue.

JUDGE MASTERSON: Or equal protection. Because follow that where it leads. It leads to us conferring by judicial decree all of the rights on children, maybe you draw the line at 7, maybe you wouldn't, that are now conferred on them by law at age 21, 18 in other states.

MR. FERLEGER: No. I think it is different (20) when it involves institutionalization, when it involves treatment for mental health problems.

JUDGE MASTERSON: Children can not be treated differently than adults, the theory is, in this setting. Then that means if it is true in this setting, it ought to be true in any other setting, and I don't think I am going to go that far. I am not prepared, by judicial decree, to say that 12 year olds are as mature as 18 or 21 year olds.

JUDGE GIBBONS: For example, would you go so far as to say that a 12 year old should be free to consent to an amputation?

MR. FERLEGER: I have been doing some research in the past couple of weeks on sterilization in juveniles in Pennsylvania, about which there is very little, almost no law.

In that kind of situation I would like, as I would in the hospital situation, some independent person to make that kind of decision.

In the hospital situation, if a child—

JUDGE GIBBONS: If the independent person designated, until the State takes steps under existing statutory authority, to substitute another guardian, is the patient's guardian. The parent—

(21) MR. FERLEGER: Your Honor, for the situation that Judge Masterson asked about, I am not saying that a child can come to the hospital and sit down and say, "I am staying here. You have to treat me." That is not what I am saying.

Under the law, and under what I am proposing, the hospital would have to make its own examination to determine if the child was mentally disabled.

JUDGE MASTERSON: It is a little inconsistent. You are willing, in effect, to take the hospital as the substitute guardian in the child voluntary setting, but not in the involuntary parental application setting.

JUDGE GIBBONS: If they are nonadversary in one, why are they not nonadversary in the other?

MR. FERLEGER: The reason Your Honor is that when it involves an involuntary commitment, when it involves saying to a child that you have done things and this means you are sick, and you have to stay here, that doctors in the hospital shouldn't be making that decision. When it involves a child saying, "I want to be here." Then the State doesn't have any authority—

(22) JUDGE MASTERSON: How about the situation where the child is angry at its parents and, you know, doees this to wound the parents and persuades the doctor, well, maybe the kid can use a little treatment for a week or two and now the parents can't get their own child back? That is a little frightening to me.

MR. FERLEGER: Well, it is. The thing, though, that is more frightening to me is the parents who are angry at the child and take the child to the hospital.

JUDGE MASTERSON: Right. That is why I would like to get some of the real facts. I think, by and large, most parents discharge their parental functions with respect to their children in a responsible way. I think most parents love their children and behave in that fashion. I think that this whole lawsuit is about very very few parents who either, through ignorance or their own emotional problems, abuse the parental right and attempt to have State agencies reinforce their abuse. I don't think there are very many of those cases and I wouldn't want to upset the whole parent-child relationship in this, and in other respects simply (23) because there may be a few cases where this abuse occurs.

So I think we would like to get some kind of factual record. When is that study going to be completed?

MR. FERLEGER: Well, the people who are doing the research have agreed with me that they will, even though they are not complete with the study, they will provide answers and statistics from the study even before it is completed. I will be getting an affidavit—

JUDGE MASTERSON: Let's talk about what kind of facts we want and how we could get them.

JUDGE GIBBONS: Before we go into that, let me ask this. Among the original plaintiffs, how many are still in Haverford?

MR. FERLEGER: There is one person that the State said the patient was on a short term leave. I am not sure, as of now, whether or not he is still at the hospital.

There is another plaintiff who I am near certain is still in the hospital.

JUDGE GIBBONS: Well, we can hardly act on near certainty. If there is nobody in the (24) hospital, a good part of your case is moot, particularly your contentions with respect to voluntary admission, because none of those plaintiffs are seeking voluntary admission.

Now that brings up the next question. These are all children, minors, and there is at least some indication that some of them may be actually, or potentially, unstable. It seems to me that we have to get some information about whether or not they would be adequate class representatives. We can't proceed even with a class suit without a live plaintiff.

JUDGE MASTERSON: And we have a preliminary threshold question; can someone who is not Sui Generis

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be a class plaintiff, or would we not have to appoint, or have you go to the local Court to appoint a guardian?

MR. FERLEGER: Your Honor, my understanding of the law in this regard is that the Federal Court would apply for this purpose, for competence, the State law. We have brought this action as a complainant case as the next friend of the plaintiffs.

JUDGE MASTERSON: How do you get to be the (25) next friend. It is usually the parent, and if not the parent, if you are representing the person of a minor, you have to be appointed guardian of the person.

MR. FERLEGER: For incompetence I believe Pennsylvania State Law, and I believe for minors, permits the person to choose—

JUDGE MASTERSON: The parents of someone in Loco Parentis, how do you get to be in Loco Parentis?

MR. FERLEGER: According to Pennsylvania law, a person in Loco Parentis does not have to be appointed by the Court. A person in Loco Parentis—

JUDGE GIBBONS: How do you get to be that person?

MR. FERLEGER: Well, in a number of ways: One way being that my job, my relationship with Haverford State Hospital, it happens to be the defendant, is to represent patients there, to act for patients.

JUDGE GIBBONS: First of all, if you have a connection with Haverford State Hospital in some official capacity, if I were sitting in the Orphans' (26) Court that would rule you out as a guardian.

MR. FERLEGER: Your Honor, not in that sort of official capacity. My connection with Haverford State Hospital is to provide independent legal advocacy—

JUDGE GIBBONS: All right. Let's assume that, and let's assume you would qualify as such a person. You have not, at least on the papers I have seen, we have individual plaintiffs acting thus far in their own right. It seems clear from the papers before us that as to some of those plaintiffs their case is now moot.

As to the others, their case may not be moot, but we need a good deal more guidance than we now have as to whether or not they are adequate class representatives, and also whether or not they can proceed without a guardian of their person. And if they can not, who that guardian should be, and if such a guardian is appointed can he also act as a class representative? There are potential conflicts too that would concern me that grow out of the potential difference in the problems of the 17 year old as contrasted with the 13 or the 6 year old. And query, if the same person could act for (27) all of those people.

MR. FERLEGER: In terms of the class representative adequacy I would like to make a couple of points.

First, that there have been a large number of cases, the most well-known recent one is the Wyatt v. Stickney case in Alabama; persons who are in mental hospitals, in person, you don't have to be an incompetent to be a patient, wherein patients have been class representatives. In terms of the adequacy of the factual background, I believe that the Interrogatories which we seek to have answered, one of the reasons we asked this portion of them was to find out what the class consists of in Pennsylvania.

We have asked the State to provide the names and the situations of the juveniles who are now incarcerated against their will. If the Court knew that, the Court would be in a better position to determine the adequacy of our representatives.

JUDGE MASTERSON: All right. Well, that raises a question that I guess we might as well address ourselves to, to the Commonwealth's motion—

(28) MR. FERLEGER: I didn't hear you.

JUDGE MASTERSON: The Commonwealth's resistance to answering your Interrogatories.

Are you continuing to resist answering those Interrogatories?

MR. ROTH: Yes, Your Honor. We are continuing to resist answering for all the institutions.

JUDGE MASTERSON: Why? Simply because it is such a big job?

MR. ROTH: Not only that, but there really has been no determination on our Motion to Dismiss. Notwithstanding that, and not to mislead anyone, we informed Mr. Ferleger he may go to the various institutions and obtain the information as well as we have gone ahead and received all the materials from our State schools and hospitals.

Now Mr. Ferleger has defined facilities as including day care centers and we have over 600 facilities in the State. We are going throughout the entire State having the information collected. We did furnish him with the Haverford material at the outset, and we are not going to deny furnishing him with this material, but before we

want to go on, and if we need to be corrected we will, but before (29) we went to proceed and continue this burdensome procedure, we wanted to know if our Motion to Dismiss would be granted.

JUDGE GIBBONS: I think we can assume; that without a record we are not going to grant your motion, except to this extent: I think, and frankly you don't even want this relief, I question whether the hospital is a proper party. It is not a person within the meaning of Section 1983. It may be that because of some features of Pennsylvania law it may be suable under Federal jurisdiction or you may be able to find a State remedy that would be picked up 420's C Section 1988. But on the surface it would look as if the hospital would be entitled to get out, because it is not a person. That would not end the lawsuit, of course, and I don't know how interested the State would be in gaining that small technical advantage.

But as far as the rest of the lawsuit I think you can assume that we will want to make a record before we decide whether or not to dismiss.

MR. ROTH: Your Honor, if I may, we have been talking about the proposed regulations and they were to be effective on May 1. However, we received (30) several comments about these regulations, and the main comment was, how do we provide for mentally retarded children in the sense of what opinion can be forthcoming for them. So we have amended our regulations which I am prepared to give you a copy of, and we are going to publish these in the Bulletin to take effect July 1.

In addition to what we already had in the regulations published March 24th, we have provided that after

six months a review will be taken, an evaluation of those proposals, and if necessary we will hold public hearings. We don't want to mislead anyone into thinking that by publishing these we are afraid of this lawsuit, and we are trying to resolve it that way. We are most concerned, above all, of the fact of stripping parental rights, and that is our major concern in this lawsuit.

JUDGE GIBBONS: Well, it obviously is ours, as you can see from the questions that have been asked.

At the same time I think on the surface some post admission procedure along the lines that you proposed in the regulations seems singularly appropriate. I don't know what the amended (31) regulations will provide with respect to the mentally retarded, or with respect to the under thirteens, which are not dealt with in the proposed regulation.

One possible approach would be that at each facility a standing Guardian Ad Litem, someone in the nature of a guardian, be appointed to review automatically after a certain length of time. And by suggesting that I don't even suggest that it is a good idea because we don't have enough facts.

MR. FERLEGER: Your Honor, I agree completely in terms of the facts, one, that is one reason why we pressed for the Interrogatories, because I don't have at this point, and the Court does, a list of the procedures that are used for juveniles.

JUDGE GIBBONS: Will there be any difficulty about that now that you know we are not going to, at least at this stage, grant your motion?

MR. ROTH: No, Your Honor. What we can do is go ahead with the State schools and hospitals.

With regard to day care centers and—

JUDGE MASTERSON: Well, wait. Are you (32) challenging procedures relating to the day care centers, and schools, or is this confined to mental hospitals?

MR. FERLEGER: I am not asking for procedures in terms of day care centers. I think Mr. Roth is misreading the State law definition for facilities. What we are asking for is for information about commitments to institutions which deal with mentally disabled people.

JUDGE GIBBONS: Well now, can you at least limit it to residential institutions?

MR. FERLEGER: Certainly.

JUDGE GIBBONS: There are mental health facilities that are on an outpatient basis.

MR. FERLEGER: Certainly.

JUDGE MASTERSON: All right. Now what does that mean in terms of the size of the job? How many residential mental institutions do we have in this State?

MR. ROTH: That would be impossible for me to answer. I can find out. One thing you have to realize—

MR. FERLEGER: I think that Mr. Roth's partial answer to Interrogatories gave us a complete (33) list of inpatient facilities.

MR. ROTH: You are talking about residential units.

JUDGE MASTERSON: We are limiting this to residential. That is what I want to know. How many inpatient residential mental hospitals do we have in the Commonwealth?

JUDGE BRODERICK: It can't be any more than 25.

MR. FERLEGER: It is certainly less than what we have here. Some of the inpatient facilities are regular hospitals with 5 to 10 beds. So some of them are only emergency. We are not talking about them.

JUDGE MASTERSON: Why don't you and your opponent here sit down and work out a schedule for the production of the information you need that is relevant to this case?

MR. FERLEGER: Certainly.

JUDGE MASTERSON: And you can be advised that the Court will require you to answer the information with respect to inpatient residential mental institutions only at this stage. Okay?

MR. FERLEGER: Certainly.

(34) JUDGE MASTERSON: Well, that seems to be the first step. Then the next step is that we would like to be briefed on the legal questions we have raised. The capacity of any of these minors to bring this action; the capacity of them to be "class representatives", the question of whether a Guardian Ad Litem should be appointed and who appoints them. And what else?

JUDGE GIBBONS: And how the class should be defined and whether or not subclasses, based on age or condition, or other considerations possibly even based on sex of the juvenile might be appropriate. I think they should certainly be brought before us on a motion to determine the class.

JUDGE MASTERSON: Yes. Right.

JUDGE GIBBONS: And with appropriate papers and with testimony, if necessary, if there are contested facts.

JUDGE BRODERICK: I am concerned about the Interrogatories, the answers. I am not so sure that I know how broad the question was, but I would certainly want to know what the present procedures are for the admission of children into those inpatient institutions, not just the inhouse (35) procedures as to how they get out, but I also want to know how they get in.

MR. FERLEGER: Those are covered by our questions 7 and 8. They are not answered.

JUDGE BRODERICK: They are covered in the Interrogatories?

MR. FERLEGER: Yes, Your Honor.

JUDGE BRODERICK: All right.

JUDGE MASTERSON: Do you need any more guidance from us right now?

MR. FERLEGER: I am not quite clear Mr. Roth has agreed to answer questions 7 and 8 involving the procedures.

JUDGE MASTERSON: He has been directed to answer them with respect to all inpatient residential mental institutions. Now if he has to be hit over the head with a brick that can be done too.

MR. ROTH: I am certain that is not necessary. I have just one question.

In bringing out the evaluation of these people perhaps it would also be worthwhile to know whether or not

the juvenile, when admitted to the institution, number one, had the capacity to even exercise the judgment to reject institutionalization. (36) I think that is a very severe question.

JUDGE MASTERSON: It is a very serious question.

JUDGE GIBBONS: That is one of the reasons why we have to get into subclasses.

MR. FERLEGER: Your Honor, I want to make one final point to your comments before, Judge Masterson.

Involving the general procedure in Pennsylvania which covers adults, which is, in fact now a situation in which the Courts do review every situation where an adult is put into a hospital against his will—

JUDGE MASTERSON: I find that really hard to believe.

MR. FERLEGER: I know. That is why I wanted to explain. Maybe I can get you some information of the number of commitments involved because I am not really clear whether it would really be any burden on the Master, the Judge who holds the hearing to hold two or three more hearings a week for three 17 year old kids.

JUDGE MASTERSON: We will get into the statistics. You will develop it here.

(37) MR. FERLEGER: That is correct, Your Honor.

JUDGE MASTERSON: All right. Now the question is scheduling. How long will it take to get the factual information together?

MR. ROTH: I would assume that is going to take a good deal of time.

JUDGE MASTERSON: Such as what?

MR. ROTH: I would like to request 90 days.

MR. FERLEGER: Your Honor, they have had the Interrogatories since 1972, since the end of December, 1972. In their memorandum they told the Court that we are working on getting the information together. I think if they have been working on it for 4 or 5 months—

JUDGE GIBBONS: Well, as a practical matter 45 days would get into the summer in any event. How about August 1st so that he can come back to the Court with any necessary discovery motions, and I certainly hope there won't be any during the month of August.

JUDGE MASTERSON: All right.

MR. ROTH: I will try my very best. As (38) you can understand the State procedure and going through your regional deputies and superintendents, including all inpatient residential centers, it is vast, and not only doing that but going back over those who already submitted information and requesting whether or not the juvenile rejected his admission and also whether or not he was capable of understanding his—

JUDGE MASTERSON: Well, it is going to be a big job for some people. It seems to me that all we are going to need is the statistical readout; how many of them objected, how many, in the opinion of the institution, had the capacity to object rationally, and et cetera.

MR. FERLEGER: Your Honor, what you have asked for, and the Court needs in terms of Judge Broderick's procedures, is the precipitated behaviors, the kind of things these juveniles were doing that brought him here.

JUDGE GIBBONS: That is a confidentiality problem there. If you are looking for that information for statistical purposes only, I assume you would have no objection to maintaining the confidentiality of identity.

(39) MR. FERLEGER: Of course not.

Could I ask the Court, since Mr. Roth has said he already has some information, especially on the policies questions that Judge Broderick asked about, could Mr. Roth give us, in the near future, the information he has now?

JUDGE MASTERSON: He should give you now whatever he has and keep feeding to them whenever you get it so there isn't any unnecessary delay.

Now that also gives you the same amount of time to supply us with the briefs we requested on the legal questions. So you have a big job ahead of you, both of you.

MR. FERLEGER: Your Honor, if the information is to be provided by August 1st, I would suggest about two weeks after that, if there is no more discovery, for the briefs which would discuss the case.

JUDGE GIBBONS: That is fine.

JUDGE BRODERICK: Fine.

JUDGE MASTERSON: Is August 15th a weekday?

JUDGE GIBBONS: August 15th is a Wednesday.

Now I think I would just like to add a (40) word on this discovery program about my own attitude on this.

We can only act in the context of a lawsuit, but in fact what we are being asked to do is to examine legislation and possibly to legislate. And I think that both of you should enter into some sort of a cooperative effort to get us the kind of information that you would give to a legislative committee studying this problem. We really need help. I frankly say I am very troubled by this case and I would not want, considering the nature of the problem, to see it go forward with a lot of Mickey Mouse on discovery.

MR. ROTH: We are at a loss too in the sense that we don't know what else could be done other than giving the plaintiffs the relief they seek by providing hearings prior to commitment of juveniles, and we can't do that. We wouldn't want to strip parental power that way, and we have tried to implement additional safeguards which we feel to be acceptable. I am willing to discuss with Mr. Ferleger any other recommendations he would like to include in the amended proposals and perhaps we could solve the case that way, but my understanding (41) at this point is that nothing short of the relief he seeks will be acceptable to him.

JUDGE GIBBONS: Well, at that point if you can agree on 70 per cent of the problem, and you have to come back to us and take testimony on the balance, we will hear what the experts have to say.

JUDGE MASTERSON: Yes.

Incidentally, on that subject we expect, on the testimonial phase of the case, to have real experts advise us, because it is a very very delicate, sensitive problem. All right.

MR. ROTH: Yes, sir.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: All right. They are scheduled to file their papers August 15th. We will determine a hearing date after we get your papers, hopefully in September.

MR. FERLEGER: Thank you.

MR. ROTH: Thank you, Your Honor.

MR. O'SHEA: All rise.

(Whereupon the Court recessed.)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

INCARCERATED JUVENILES—WHY? THE MENTAL INSTITUTIONALIZATION OF JUVENILES IN PENNSYLVANIA

An Analysis of Data Submitted by Defendants in Response to Interrogatories by Plaintiffs

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I. INTRODUCTORY COMMENT

This is a review and content analysis of facts of record in this case regarding the reasons juveniles are institutionalized in mental facilities in Pennsylvania. The indented and other quotations, unless otherwise indicated, are the reasons given by the *institution and doctors themselves* for the confinement of the juvenile.

II. EXTENT OF INFORMATION

On September 15, 1973, Plaintiffs filed an analysis similar to the one below based upon information regarding

state institutions for the retarded. Since that time, the Defendants have provided information regarding juveniles in the twenty state mental hospitals and this new data has been incorporated into this study.

While—as the tables below indicate—the Defendants have failed to provide all the information this Court required, enough is presented to provide a substantial factual basis for the proceedings in this matter.

The raw material analysed below is in the record of the Court and includes a survey of all mental facilities in Pennsylvania operated or licensed by the Defendant Department of Public Welfare. Data was collected on the admissions of juveniles, the reasons for such admission and the relationship between the applicants and the juveniles.

III. WHAT IS SHOWN—IN GENERAL

The record depicts numerous private tragedies and gross personal and medical difficulties in which it is appropriate for the juvenile to be maintained in an inpatient residential setting.

However, as detailed below, there are many cases in which it is shocking that institutionalization was resorted to or in which it was done not to benefit the child but to benefit the parent or parents. There is little support here for a blanket presumption of proper medical or parental action.

Many of the children in institutions are there because of difficulties adjusting to the norms of our society. The psychological term often applied is "Adjustment reaction of infancy and childhood"; this is attributed to the greater

fluidity of all behavior at this age and characterized by such symptoms as overactivity, inattentiveness, shyness, feeling of rejection, over-aggessiveness, timidity and delinquency.[1] Difficulty in school, problems with peers, drug usage, hostility, aggression, and temper tantrums are frequent reasons given for institutionalization of juveniles. The factual allegations supporting such descriptive conclusions are often in dispute and there is at present no procedure by which such disputes may be resolved so that institutionalization may be compelled on a fair basis.

Many children are committed to mental institutions for "delinquent" non-"insane" behavior, or because parents don't care, or simply because someone didn't know what else to do with them. The following reason given for commitment of a 17 year old male to Holidaysburg State Hospital is a sad comment on this situation:

> Mr. ———— was admitted to the Cresson State School and Hospital in July, 1965. In February 1971, he was admitted to the Western State School for an evaluation. He was found to have an I.Q. too high for residency in a state institution for the retarded. Despite the absence of psychotic symptomology, he was ordered admitted due to a long history of emotional deprivation and institutionalization during a critical developmental period of his life.

Six juveniles at Western State School and Hospital were committed under sections of the 1951 mental health law and nobody has bothered, in the seven years since the 1966 law was passed, to have proper commitments instituted. A more inexcusable fact is that Pennhurst

[1] Diagnostic and Statistical Manual of Mental Disorders (DSM II), American Psychiatric Association ( ).

State School and Hospital admits that four patients (Nos. 146 to 149) have "no commitment", in other words, the state has been holding these people with *no legal authority whatsoever.*

Although incomplete information often lists MR (mental retardation) as the reason for commitment for many persons, when one looks at the complete replies of Pennhurst (where all patients are retarded), one sees the actual behaviors which provoked institutionalization (*e.g.*, runaway, incorrigible, abusive, assaultive, self-destructive, impulsive).

In a large proportion of cases, it is not even the parent who initiates the commitment. A social welfare agency, a juvenile court, a relative or others, place dozens of juveniles in institutions "voluntarily".

It is clear that some screening process is necessary. There are some persons whose commitment is or may be justified under the law and some who ought not be committed. Neither the parents, the hospitals nor the welfare agencies are presently protective of the rights of these juveniles. The question before this Court is whether the "applicants" under Sections 402 and 403 plus the medical staffs are sufficient "screens" or whether the impartial court must step in.

The examples below indicate the miserable failure of the present state of affairs, the state of affairs which the Defendants herein ask this Court to allow to continue.

IV. BEHAVIOR SIMILAR TO DELINQUENT BEHAVIOR

Many parents and agencies have institutionalized children for behavior which, if brought to the juvenile court's

attention, would have required the due process protections of the Constitution; by using the mental health process, the parents were able to avoid a hearing:

> Runaway, incorrigible (Pennhurst, No. 402).
>
> Violent episodes (Polk, No. 13, 173).
>
> Hostile, attacked children, attempted to set home on fire (Polk No. 13,077)
>
> Robbed gas station (Mental Health Center of Carbon, Monroe, Pike Counties, No. M-0-0543).
>
> Stole truck, car (Mental Health Center of Carbon, Monroe, Pike Counties, No. M-0-1210).
>
> Member of gang which participated in Robbery (Thomas Jefferson University Hospital No. 360233).
>
> Stealing (Northwestern Mental Health Center, No. 628).
>
> Involved in an altercation with a 10 year old girl whom he chased and struck (Allentown State Hospital No. 25380).
>
> Fire setting (Northwestern Mental Health Center, Inc. No. 620).
>
> Delinquent Behavior (Northwestern Mental Health Center, Inc. No. 637).
>
> Fire setting (Northwestern Mental Health Center, Inc. No. 61).
>
> Runaway (Northwestern Mental Health Center, Inc. No. 188).
>
> Arson (Fairmount Farm, No. 16380).
>
> Runaway (Fairmount Farm, No. 16187).
>
> Firesetting, stealing (Western, No. 281).
>
> Runaway, truancy, delinquent behavior (Western, No. 288).

For similar reasons, the courts commit juveniles to these *same institutions,* for example:

> Aggressive behavior towards family. Refusal to attend school.
>
> Excessive demands of attention at home. (Western, No. 285).
>
> Charged with arson and delinquency (Eastern Penna. Psychiatric Institute).

If the applicants for "voluntary" commitment had chosen to bring the above behaviors to the attention of the juvenile court, due process hearings would have been afforded the minors. In Re Gault, 387 U.S. 1 (1966); Kent v. United States, 383 U.S. 541 (1966); In Re Winship, 397 U.S. 358 (1970). The rehabilitative institutionalization of the juvenile court process requires such hearings. However, since the applicants chose to bring these juveniles to the mental hospital, rehabilitative institutionalization was accomplished without any process at all.

V. COMMITMENT FOR BENEFIT OF PARENT(S)

These instances are the most disturbing for they prove how the mental health facilities cooperate with parents and relatives in doing what Judge (now Chief Justice) Burger called

> "farming" out their kindred into mental institutions for motives not always worthy.
>
> Kent v. United States, 401 F.2d 408, 416, footnote 4 (D.C. Cir. 1968) (dissenting).

For example, one child wound up at Polk for an "interim placement while family was on vacation." No. 13,212. A mother placed her child at Western simply

because "Father out of household in the military." No. 144. One juvenile's "hyperactivity interfered with the routine of household and disturbed family members." Western, No. 15.

A newly widowed father was able to place a youngster at Western because he allegedly was "unable to care for child." No. 67. The same hospital accepted a child from a mother because of "desertion of father." No. 131.

In another striking case, a mother and father who had emotional difficulties themselves institutionalized their child at Polk because they held the "problems of the child . . . responsible for their emotional adjustment." No. 12,482.

One institution accepted a juvenile because: "Difficult to care for Loretta and her presence confines the parents in the home." Western, No. 73. A boy named Joseph left "no free time for mother." Western, No. 13. If these are proper reasons for depriving someone of liberty, then the state could summarily lock up almost every child that parents present at the hospital doors.

In numerous cases, children are the ones who are forced into treatment when it is the *family* as a whole which, according to the hospitals, has the problems. See Henry, *Pathways to Madness* (1973); Esterson and Laing, *Sanity, Madness and the Family* (1964):

> Family Problems (Philhaven Hospital, No. 5647)
>
> Family Conflicts (Institute of Penna. Hospital, No. 94-94-33)
>
> Family problems, needed separation from the family (Wernersville State Hospital)

In similar cases, it is the least powerful member of the family—the child—who is shunted off to the mental hospital when the parents decide they cannot or do not wish to deal with the situation:

> Unmanageble at home, attitude of bold indifference, resents all discipline, compulsive eating (Allentown State Hospital, No. 25741)
>
> Problems with family (Philhaven Hospital, No. 5692)
>
> Began to have trouble handling his angry and hurt feelings toward his parents. Took these feelings to school with him. (Allentown State Hospital No. 25520)
>
> Runaway, Conflict with Parents (Institute of Penna. Hospital No. 94-93-74)

VI. "WHICH CHILD DO WE COMMIT?"

Families with more than one child may use the mental hospital as a way of reducing the number of family members. For example,

> Physical burden on mother who has three additional children. (Western No. 36).
>
> He is one of three mentally retarded in the family. Coping with this problem is simply too much for the family. (Polk No. 13,103).

When a decision is being made as to which, if any, of three children is to be deprived of liberty, is this a medical decision? Will there be any protection for the child whose "number is up"?

VII. JUVENILES COMMITTED BECAUSE OF PARENT'S PROBLEMS

In a suprising number of cases, there was nothing serious reported wrong with the child but a parent's problem caused a commitment. A few outstanding examples:

> Became argumentative and wanted to stay out of school. Patient's mother overdosed and was hospitalized. Patient then had to be hospitalized. (Warren State Hospital).
>
> Neglect, Social Deprivation (Stillmeadow Home for Exceptional Children No. 1145).
>
> Neglect, Unstable home environment (Stillmeadow Home for Exceptional Children No. 1138).
>
> Mother has tuberculosis. (Western, No. 129).
>
> Emotional instability of mother. (Western, No. 127).
>
> Hospitalization of mother is apparent reason for admission. (Polk No. 11,985).
>
> No serious behavior problem; admitted due to parent's inability to provide a satisfactory home environment. (Laurelton No. 42).

A court hearing could have explored the facts in these cases, and found a less restrictive alternative which would not punish or "treat" the child for a parent's difficulty.

VIII. IMPROPER BASIS FOR INSTITUTIONALIZATION

Despite Levy v. Louisiana, 391 U.S. 68 (1968), and similar cases, these were the sole reasons Western gave

for the commitment of three persons to that institution (all signed in "voluntarily" by the mother):

> Quite active and destructive. Illegitimate. (No. 226).
>
> Sometimes hyperactive. Illegitimate. (No. 228).
>
> Illegitimate. Inadequate mother. (No. 227).

Polk readily accepted a young boy for this rather unusual reason:

> "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the TV at home," stated the parents. (No. 12,836).

Although a child could have been receiving "training for autonomy," the parents wanted only "services and sheltering" so one young woman remains at Polk without such training. No. 13,221. The only reason given for one patient is "Admitted to Polk State School and Hospital for educational purposes." No. 12,811; state law now requires public schools to provide education to all, including the retarded.

IX. INSUFFICIENT BASIS FOR INSTITUTIONALIZATION

Physical Problems Alone

Three children were committed to mental hospitals because of physical ailments. At Saint Francis' Hospital one child was committed for ulcerated colitis (No. 13-58-69); another for psychosomatic complaint (No. 11-81-06). A third child was put in the Institute of the Pennsylvania

Hospital for weight loss (No. 94-88-05). A physical ailment alone is an insufficient reason to put an individual in an institution.

School Problems Alone

There are 5 children in Saint Francis' Hospital for not going to school. This list is as follows:

School phobic (No. 12-87-29).

School phobic (No. 12-80-40).

School phobic (No. 11-17-68).

Non-school attendance (No. 14-57-10).

Non-school attendance (No. 14-18-89).

Not going to school hardly seems sufficient reason to commit a child to a mental institution.

Drugs

It is understandable that when a parent finds his child is using drugs he becomes concerned and looks for help with the problem. Under the existing laws concerning juvenile commitment it is too easy for a parent or guardian to evade their responsibilities by having the child commited. Drug usage alone is not a sufficient reason to commit a person to a mental institution unless the facts and alternatives have been considered by a court. A partial list of juveniles committed for drug related activities is as follows:

Mental Health Center of Carbon, Monroe & Pike Counties:

Overdose (No. M-0-1174)

Overdose (No. M-0-1165)

Drugs (No. Z-0-1104)

McKeesport Hospital:

Medical overdosage (No. S.K.)

Medical overdosage (No. R.M.)

Medical overdosage (No. R.W.)

Medical overdosage (No. R.K.)

Medical overdosage (No. T.G.)

Medical overdosage (S.C.)

Medical overdosage (T.S.)

Fairmount Farm:

Drugs (No. 16155)

Drugs (No. 16147)

Drugs (No. 16027)

Institute of the Penna. Hospital:

Drugs (Nos. 94-90-72, 94-95-23, 94-93-00, 94-94-92, 94-93-52, 94-91-42, 94-95-32, 94-95-57, 94-91-87)

One juvenile has even been committed for a *"fake* drug overdose." St. Francis General Hospital, No. 11-85-22).

X. ILLEGALITY OF GENERAL ADMISSIONS

Mental health facilities are required by the mental health act to receive patients *only* pursuant to the statutory provisions of the statute. However, 11 facilities for which data was provided admitted that, rather than using the proper provisions of the law, they accept mentally ill juveniles as "general admissions."

This illegal method of commitment denies to juveniles the presently scant protections of Sections 402 and 403

and also denies them the protection of the new regulations the state has adopted.

By going outside the mental health act, the patients' rights (Section 423) need not be enforced and other rights are denied, e.g. the right to be discharged when treatment is completed (Section 418), the right to leaves of absence (Section 419), the right to review by the Department (Section 420).

These are the facilities which presently act in this improper manner:

Happy Hill
Don Guanella School
St. Mary of Providence School
Ivy Mansion for Exceptional Children
The Evans School
Clifford Nursing Home
Camphill Special School Inc.
Greenwich Home for Children
Refuge Home for Children
Merry Acres
Pleasant Manor Inc.

XI. CONCLUSION

The above data show that special, personal and legal judgments enter into decisions to institutionalize juveniles; by no means is it purely medical decision. Indeed, where the medical people are involved, as in all the cases cited above, abuses still occur.

The wisdom of allowing and requiring courts to determine whether someone should be institutionalized is

brought into clearer focus by the goings-on which the present mental health system permits. As the tables below, especially Table 3 indicate, it would be no great burden on local courts to hold hearings for the small number of juveniles admitted each year. For example, the county in which Polk State School and Hospital is located would have had only 33 additional hearings last year; Whitehaven patients would have required only 87 hearings.

When facts are disputed and careful judgments must be made, especially where objections are made (even though there is presently no right to object), and where adverse interests are involved, there is no reason shown in the data above why juveniles should be denied the same due process as adults get in the mental health setting and as other juveniles get in the juvenile court context.

Respectfully submitted,

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March 26, 1974

TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members*	Misc.	Not Given**
Polk	341	0	0	330	39	0	1	1	1
Ebensburg	619	0	0	595	24	0	0	0	0
Pennhurst	109	1	0	93	5	1	2	0	4
Cresson	238	0	2***	209	25	0	5	1	0
Selinsgrove	225	0	0	196	7	0	3	0	20
Western	291	8	0	267	7	4	5	11##	5
Laurelton	70	4	0	58	6	0	2	1	0
Whitehaven	169	0	0	123	8	0	1	1	36
Hamburg	214	0	0	?*	?	?	?	?	?

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
*** These two persons are transfers from other facilities; they are listed as "voluntary" but no applicant with appropriate legal section is given.
These 11 persons' applicants are listed as "Entrustment Agreement."
* No detailed information was provided by Hamburg State School and Hospital.

All entries refer to the number of cases involved.

Incarcerated Juveniles - Why?

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TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members	Misc.	Not Given
Allentown	71	9	1	10	2	0	1	0	60
Hollidaysburg	1	1	0	2	0	0	0	1	0
Harrisburg MH & R Center		1	0	1	0	0	0	0	0
Somerset	1	16	1						20
Fairview		0	0	0	0	0	0	0	0
Philadelphia	0	0	1						
Warren	0	5	0						
EPPI	17	2	0	15	4	0	0	0	0
Norristown	14	4	0	15	0	0	0	2	0
Torrance	0	3	0	2	0	0	1	0	0
Wernersville	33	0							
Haverford	10	113	0						123
Retreat	0	4	0	3	0	0	1	0	0
Harrisburg St. Hosp.	9	6	0	8	2	0	1	4	0
Mayview		1				1			

Incarcerated Juveniles - Why?

TABLE 2 -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 406	Not Given**	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members*	Misc.	Not Given**	Incarcerated Juveniles - Why?
Polk	13	0	0	1	7	9	0	1[a.]	0	
Ebensburg	12	?	?	?	?	?	?	?	12	
Pennhurst	44	3	3[b.]	34	4	1	0	0	11	
Cresson	0	0	0	0	0	0	0	0	0	
Selinsgrove	3	0	0	2	1	0	0	0	0	
Western	6	0	6[c.]	2	3	4	0	1[d.]	1	
Laurelton	6	0	0	4	1	0	0	1[e.]	1	
Whitehaven	2	0	0	0	0	2	0	0	0	
Hamburg	20	0	0	16	2	0	2	0	0	

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
a. The petitioner was the Superintendent of Polk.
b. These were 3 transfers under Section 416.
c. These 6 were under the 1951 law.
d. The County Mental Health Administrator.
e. "Deputy Administrator of Juveniles and Misdemeanants."

All chart entries refer to the number of cases involved.

TABLE 2a -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 406	Not Given	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members	Misc.	Not Given	Incarcerated Juveniles - Why?
Allentown	3	0	0	3	0	0	0	0	0	
Hollidaysburg	1	0	0	1	0	0	0	0	0	
Harrisburg MH & R Center	0	0	0	0	0	0	0	0	0	
Sommerset	1	0	0						1	
Farview	0	0	4	0	0	3	0	0	1	
Philadelphia	7	0	0							
Warren	22	0	0							
EPPI	1	0	0	1	0	0	0	0	0	
Norristown	13	0	0	3	0	1	0	8	0	
Torrance	3	0	0	0	0	3	0	0	0	
Wernersville	3	0	0							
Haverford	24	0	31						55	
Retreat	1	0	0	0	1	0	0	0	0	
Harrisburg St. Hosp.	10	0	0	3	4	0	0	3	0	
Mayview										
Woodville	8	0	0	0	0	7	0	0	1	

TABLE 3

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILI

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given*
Polk	33	0	0	0
Ebensburg	?	?	?	all
Pennhurst	11	0	30	0
Cresson	?	?	?	all
Selinsgrove	?	?	?	19
Western	55	3	2	0
Laurelton	29	?	?	2
Whitehaven	87	0	2	0
Hamburg	15	0	3	0

* There is no explanation for these omissions in the data supplied by Defendants.

TABLE 3a

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given
Allentown	65	23	2	
Norristown	17	11	15	
Hollidaysburg	0	2	1	
Sommerset	{28}		0	
Farview	0	0	0	0
Philadelphia	9	2	4	
Harrisburg MH & R Center	0	1	0	0
Warren	4	0	12	0
EPPI				
Torrance	0	4	2	0
Wernersville	12	0	3	0
Haverford	10	113	24	0
Retreat	3	1	1	0
Harrisburg State Hospital	7	13	14	0
Mayview				
Woodville	4	20	7	0

TABLE 4

OBJECTIONS TO TREATMENT *

Name of State School and Hospital	Objected at or after Commitment	Capacity to Object Yes	Capacity to Object No
Polk	0	--	--
Ebensburg	?**	?	?
Pennhurst	0	--	--
Cresson	?	?	?
Selinsgrove ***	15	52	3
Western	15	6	8
Laurelton	7	3	4
Whitehaven	?	?	?
Hamburg	0	0	0

* All the data here are questionable both in terms of their incomplete and the fact that the replies are frequently qualified by such terms as "objection on the record" or "don't know."

** The question marks ("?") indicate no reply by the facilities.

*** Most Selinsgrove patients, except for those tallied here, are co severely or profoundly retarded.

The capacity to object is determined solely by the facility without reported judicial determination of incompetency for that purpose.

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TABLE 4a

OBJECTIONS TO TREATMENT

Name of State School and Hospital	Objected at or after Commitment	Capacity to Object Yes	Capacity to Object No	Capacity to Object Not Given
Allentown	16	1	15	0
Hollidaysburg	0	0	0	0
Harrisburg MH & R Center	1	0	1	0
Sommerset	1	1	0	0
Farview	0	0	0	0
Philadelphia				
Warren	27	0	27	0
EPPI				
Norristown	16	4	12	0
Torrance	0	0	0	0
Wernersville	10	7	1	2
Haverford				
Retreat				
Harrisburg State Hospital	16	3	10	
Mayview				
Woodville	16	10	6	0

CERTIFICATE OF SERVICE

I certify that on the 26th day of March, 1974, I mailed true and correct copies of the foregoing to Marx Leopold, Esquire and Barry Roth, Esquire, Counsel for Defendants, at their offices at Office of Legal Counsel, Department of Public Welfare, Health and Welfare Building, Harrisburg, Pa. 17120.

William Jameson

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Caption Omitted]

ARGUMENT ON PLAINTIFFS' MOTION FOR A CLASS ACTION DETERMINATION AND ON DEFENDANTS' MOTION TO DISMISS

Philadelphia, Pa., April 16, 1974
(10:00 a.m.)

Before:

Hon. John J. Gibbons, C. J.

Hon. Daniel H. Huyett, 3rd, J.

Hon. Raymond J. Broderick, J.

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(2) Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Attorney for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

JUDGE GIBBONS: May we have the appearances?

MR. FERLEGER: My name is David Ferleger, counsel for the plaintiffs.

MR. ROTH: My name is Barry Roth, counsel for defendants.

JUDGE GIBBONS: We have this morning, in addition to the defendants' motion to dismiss, several items to which I'd like to have counsel address themselves. First, is the status of the plaintiff as a class representative, represented by a next friend, rather than a guardian ad litem. In that connection, we call your attention to the fact that in Dixon versus the Attorney General of Pennsylvania, Judge Biggs, in the opinion at 315 Federal Supplement, 653—actually, that's a per curiam, but it probably was Judge Biggs, suggests that where you seek class (3) action representation, it is inappropriate to have a person under a disability act in that capacity.

Tentatively, we think there is some merit to that position and we would like to have counsel the issue, where a guardian ad litem should be appointed and if so, who.

Secondly, the only defendants joined are state employees. We raise the question, whether or not, in the circumstances of this case, it would be appropriate to designate a class action defendant to represent the parents of class members. You will recall that Sierra Club versus Morton indicates that an organization which has members who are in the affected plaintiff class, can be a class action plaintiff.

We are suggesting at least the possibility that an organization which has members of an affected defendant

class, in this instance, parents of either retarded or mentally disturbed children, might be an appropriate class action defendant, because there is at least a possibility of conflict in the position taken by the institutional representatives and the position which should be taken on behalf of parents. We will of course hear you on the class action determination itself and finally, we will hear you on the motion to dismiss. (4) Keep in mind, that on everything that is before us, we have read your extensive briefs, and we only want to hear material that will enlighten us, beyond what you have in your briefs.

I suppose the starting place would be the State's motion to dismiss. Mr. Roth?

MR. ROTH: May it please the court, Your Honors, in connection with our motion to dismiss, I must state at the outset that the Commonwealth, in order to perhaps shorten the proceedings of this matter is basing almost entire reliance upon the regulations that were effectuated in order to continue implementing sections 402 and 403 of the Mental Health and Mental Retardation Act of 1966.

In short, Your Honors, we feel that those sections which permit a parent or person in standing in locus parentis to admit or commit his or her child, are constitutional and that they are a function of parental rights.

Now, since the inception of this lawsuit, the Commonwealth has attempted in its review of the law to determine whether or not any other cases have been brought regarding the same exact issue. At that time, we had discovered none. We did discover there (5) were serious questions as to affording juveniles the opportunity and right to be heard prior to commitment to an institution. The Commonwealth in attempting not to strip parents of

parental powers, effectuated regulations which would generally permit any juvenile, upon admission, who objects or subsequent thereto, to be afforded counsel and undergo what is known as a "406 Commitment Proceeding". It is a section 406 Commitment Proceeding under the Mental Health and Mental Retardation Act which is the section which refers to involuntary commitments of adults, meaning those who are aged 18 years of age or older.

Now, in connection with the implementation of these regulations, we consulted with opposing counsel for his comments. We had these published. Subsequently, we received criticisms and comments and suggestions and we, in September of 1973, implemented these regulations.

Now, since that time and in a conference with Judge Huyett several weeks ago, a question was raised as to how effective are the regulations. And for Your Honors, I have a copy of the number of cases since September, 1973, where a juvenile objected at or subsequent to admission and the procedure that occurred. If I may at this time, I would like to hand that to (6) Your Honors.

JUDGE GIBBONS: Thank you.

MR. ROTH: Now, our understanding of these, which were prepared by the Office of Mental Health and the Office of Mental Retardation, through telephone, contacted every private licensed facility, State mental facility, state school and hospital, was to determine exactly whether or not the regulations were being applied correctly or whether or not a juvenile who objected at or subsequent to was being given, if you will, additional safeguards, as we promulgated. It appears that in every one of these cases where juveniles objected at admission or subsequent thereto, a petition—

JUDGE BRODERICK: Mr. Roth, would you mind if I interrupted, I wanted to ask a question?

MR. ROTH: Yes, Your Honor.

JUDGE BRODERICK: I just wanted to ask you, would you tell us just what the procedure is under the regulations? I have read them over, and I just wanted a quick interpretation of what that procedure is.

MR. ROTH: Your Honors, there are specific sections in the regulations which we may classify as a referral in order to show how the juvenile arrives at the institution. In other words, he's been medically (7) examined, psychiatrically examined by a base service unit or by a pediatrician or psychiatrist. We are talking about two different classes here although affected by the same regulations and we are talking of a class of mentally retarded juveniles and those who are mentally disabled.

Now, basically what occurs, after the institution receives the application of that juvenile, the institution has an independent examination also conducted.

Now, when the juvenile is admitted to the institution, if the juvenile at the time of admission or subsequent thereto, anytime, meaning subsequent thereto, objects to his being admitted, he will be afforded counsel, he will be given the right to contact his parents or the person who petitioned on behalf of him to arrange his commitment to the institution and generally undergo a 406 proceeding. What basically happens, is the director of the institution will, if he feels that the juvenile is definitely in need of continued care and cannot be released to the petitioner, will then request that a 406 petition occur, which will basically put it before a judge in order for a hearing to be

held and to determine whether or not the person does need institutionalization.

It should be noted that we utilize two days in order to seek contacting the petitioner, as well (8) as perhaps the base service unit. We arrived at this 48-hour basis, because in Lessard versus Schmidt there was some dicta indicating that a person's due process rights should not be deprived for more than 48 hours. We even question Your Honors whether or not that should apply to juveniles because in this situation again, we are talking about the paramount rights of parents versus juveniles and that is basically what the procedure allows.

We also have a notice which is read to each juvenile, advising him or her of their rights upon admission to the institution and that juvenile has to be age 13 or older. For those that are aged 13 and younger, we provide no notice. If a juvenile is incapable of understanding what is being read to him or her, that, also is noted on the notice proper.

JUDGE HUYETT: Is there anything more done than noted on the notice that the juvenile cannot understand the notice?

MR. ROTH: No, Your Honor. If he objects, and that's the question again since our conference I tried to gather this information and one of the questions that I unfortunately did not ask when the people were making these calls was whether or not (9) those objections include people who did not have the mental capacity to exercise judgment. It is my understanding, that if you're 13 years of age or older and object and even do not have the requisite capacity to make that judgment, a 406 proceeding still will be afforded you. So, this classification,

perhaps may be broken down even more, based upon whether or not a juvenile has prerequisite mental ability to exercise judgment.

Now, the Commonwealth is aware that plaintiffs have raised a few cases in connection with procedural due process rights afforded juveniles, namely Heryford versus Park and Seville—I'm sorry, the last name escapes me. Both of those cases indicate that juveniles may be afforded due process rights.

Unlike the Pennsylvania regulations, those statutes in question do not have any other mechanism for affording a hearing upon detention, if so requested by the juvenile.

Pennsylvania feels that these additional regulations would promote and safeguard procedures for juveniles being committed to its institutions.

In connection with the entire scope of juvenile's rights, we also contend that if Your Honors (10) feel that this Statute, these sections of the Mental Health and Mental Retardation Act are unconstitutional, we seriously question whether or not deprivation of any juvenile for any amount of time, whether it is a greater or lesser amount of time, as against enunciated in Lessard versus Schmidt, would require a due process hearing prior to commitment and we refer as we referred last year this time when we were discussing this case, to particular instances where a parent may want to put his child into a general hospital for an appendectomy or anything of that sort. Certainly, we think that deprivation of liberty is deprivation whether it is one minute or 10 hours.

The question becomes, in our way of thinking is: How soon after that deprivation occurs do we resolve a

balancing interest between parents and child and state among those three parties by affording a hearing if the juvenile requests it? Now, there's been some factual data with regard to the number of juveniles who are admitted to the state schools and hospitals and state mental hospitals throughout the past year, and it's been indicated in one of the memorandums of law, as I recall, by plaintiffs, that the number is minimal and as a result, would require (11) very few hearings. Now, in just tabulating an approximate number of state schools and hospitals and state mental hospitals, it is my understanding that there were approximately 600 juveniles admitted in the state schools and hospitals and state mental hospitals for the year 1972.

Now, this precludes, of course, the private licensed facilities of which there are 164.

JUDGE GIBBONS: If I understand this paper that you handed up to us, since September of 1973, there have been 22 hearings held?

MR. ROTH: I'm sorry, Your Honor, I don't know where you are arriving at 22.

JUDGE GIBBONS: In every instance, but one that's listed here, there was a section 406 hearing.

JUDGE HUYETT: One hospital alone had 17.

JUDGE BRODERICK: There is one here that has six and another has a six and another 17.

JUDGE GIBBONS: I'm sorry. It is a good deal higher number.

MR. ROTH: Yes, Your Honor.

JUDGE BRODERICK: May I ask a question? I guess it was the plaintiff that submitted the article, the rights of a child to refuse treatment, which (12) apparently was the recommendation of the task force on mental health for children and youth. What is their status in regard to the Commonwealth?

MR. ROTH: Your Honor, I was just going to arrive at the various levels of where the legislature is, where the task force is. The task force is an advisory committee and the members of that committee are appointed by the Governor.

Now, that committee makes recommendations to the Department of Public Welfare. They are merely advisory. That same advisory committee agreed to the additional procedural safeguards which we adopted, and which is prefaced in the bulletin, also.

Now, again, you know, it puts me in a very difficult situation, because you have the task force on one hand saying "we think that a prior hearing should occur prior to commitment in every instance" and then, the department is saying "well, let's make certain that we do afford at least enough procedural safeguards that would satisfy due process". And, so, we implemented regulations to effect that. The legislature and I just want to, you know, bring everything to your attention, because perhaps, you know, it might be more helpful in arriving at a decision, (13) Senate Bill 1239 of which I have copies for your Honors, the legislature is attempting to utilize the same procedures now by having parents commit their children or persons standing in locus parentis being afforded the opportunity to admit or commit their children.

However, they want to reduce the age from 18 to 14. So, in all honesty, we are a bit scattered in the direction that's occurring, in that the senate at this time in Bill 1239, would like to have the juvenile apply for and receive treatment, if he is age 14 and older.

Under age 14, he would again be admitted or committed by his parent or the person standing in locus parentis.

JUDGE GIBBONS: Bill 1239 proposes that only the juvenile if he's over 14 can make the application?

MR. ROTH: It proposes that the juvenile shall be allowed to do so.

JUDGE GIBBONS: That's not—

MR. ROTH: I see your question.

JUDGE GIBBONS: Can the parent also do so? Do they propose that the parent also do so?

MR. ROTH: They say any person or the (14) juvenile.

JUDGE GIBBONS: That really isn't involved in this case, because as I understand Mr. Ferleger's position as distinct from the amicus brief that was filed by the San Francisco organization, the Youth Law Center, he is not objecting to the inability of a juvenile to voluntarily commit himself without his parent's consent. He's objecting to the ability of the parent to have him committed.

MR. ROTH: Yes, I understand that to be the issue also, Your Honor. I merely wanted to refer this other development as what is currently before the legislature for Your Honor's knowledge in terms of whatever you come out with in your order.

JUDGE BRODERICK: May I ask one other question? Who adopts the regulations? Is it just the department head?

MR. ROTH: Basically, Your Honors, what happens—

JUDGE BRODERICK: Would that be Mrs. Wohlgemuth?

MR. ROTH: She approves it and then they're approved by the attorney general, so in effect, it would be Mrs. Wohlgemuth's recommendation to the (15) attorney general for the adoption of the regulations?

MR. ROTH: Yes.

JUDGE GIBBONS: Do they have the force of law in this state under some administrative code?

MR. ROTH: They have the force of law under the administrative code and also under the Public Welfare code and I can give you the specific situations. I'm sorry, I do not have those citations before me.

JUDGE GIBBONS: What is your reaction to our concern about a possible representative of parent interests?

MR. ROTH: If I understand you correctly, when you were raising that, are you indicating at that time that in other words, a guardian ad litem should be appointed?

JUDGE GIBBONS: No, there are two questions. The guardian ad litem goes to the adequacy of the class representative, assuming we grant class action treatment. But that would leave a guardian ad litem as a class representative of the class consisting of actually or potentially involuntarily committed minors. It would leave the defendants, the state employees, whom you represent, but it would leave the representation of the parents who obviously have an interest in this statute in your hands.

Now, obviously, (16) the attorney general has some interest in advancing their point of view, also, I suppose, but is there a potential conflict between the interests of the institution and the interest of the parents? If so, should we consider whether or not somebody, let us say, the Pennsylvania Association of Retarded Children, which undoubtedly has members in the class of parents of the plaintiff class, should not be joined as a defendant, so that we get a different point of view?

MR. ROTH: I would think, Your Honor, in regard to that, that the state institution act is in a somewhat adversary position to the parent, and I say "adversary", in the respect that if the parent wishes to admit or commit his child and follows the procedures outlined, the institution still will have the ultimate say in whether or not that child is institutionalized based upon their independent determination—psychiatric determination.

So, if anything—

JUDGE GIBBONS: But the thing is, a parents' organization might be more interested in a longer waiting period than 48 hours and might have some cogent reasons for advancing that position. They might be interested in more freedom on the part of parents (17) to involuntarily commit than the institution is.

MR. ROTH: I appreciate that, and I agree with you, they very well may. I was just trying to look at it from the standpoint, when we are talking of juvenile rights and showing that we are taking this legal presumption and we are really making it somewhat of a rebuttive presumption that the child is not as parents have alleged, railroaded into institutions, that there is somewhat of a check by the institution proper, but I agree with Your

Honor, in connection with these regulations, parents groups did not submit any comments.

Most of the comments that were submitted were done by institutions, themselves, psychiatrists and I believe there was one comment by Park, as you referred to before, but the comments of parents' groups were not solicited, other than through the Pennsylvania Bulletin when we published the proposed regulations, but that may very well be, that a parents' group might have another view with regard to this. Our feeling is, and as you indicated before, not to go through our briefs, because of course, you have had them and read them, but our feeling is that parents do maintain certain responsibilities to their children and (18) among those responsibilities are the welfare and care of their children and the treatment of their children and included within that treatment is the medical and mental treatment and we feel very strongly that parents do have corresponding duties to make sure that their child is institutionalized, if necessary.

Now, with regard to the parents, we feel that the parents are the ones who first observed their child and were very concerned.

If this regulation is struck down, the parents and especially parents of poor socio-economic backgrounds will not utilize any type of procedure to get his or her child institutionalized. That as soon as you hear and from what I have heard in institutions, as soon as you hear the word "doctor" or "lawyer", poor people tend to preclude utilizing those systems, because based on their unfamiliarity with them, they're afraid and as a result the one that's being hurt the most is the one whose best interest we are trying to serve, the child and we think

there is a balancing interest here between the parents' and child' rights, and we hope we have established a fair balance by utilizing these additional safeguards.

Now, if those safeguards were found to (19) be acceptable, but perhaps the waiting period should be extended or something of that sort, of course, you know, we would do whatever the court ordered and we could always amend other regulations to reflect that, but with regard to the entire scope and the intent, we feel it would be absolutely anathema to parents and to the institution proper to now have to go through a procedure which basically can occur subsequent to the admission, if the juvenile objects.

JUDGE BRODERICK: Mr. Roth, let me ask you this: Have you considered what were the attorney general's or the department's objection to the recommendation for a precommitment hearing on the basis that's recommended here by the Task Force? I am sure you're familiar with their recommendation. In other words, what did the Commonwealth object to as far as that recommendation is concerned? Why wasn't it adopted, for instance?

MR. ROTH: Well, the recommendation came out after the advisory committee had already approved the regulations which were implemented.

JUDGE BRODERICK: Oh.

MR. ROTH: So, they were later and also—

JUDGE BRODERICK: The reason I ask that question, it is said in this article that was (20) submitted by the defendant, that the Task Force was asked by the Advisory Committee to make recommendations regarding ap-

propriate safeguards. It may have been afterwards, but it does not indicate that in the introduction.

MR. ROTH: I will be glad to elaborate. I approached the Task Force back in January of 1973, I guess it was and indicated the proposed regulations, and I told them at the time that what we were trying to do was afford juveniles additional procedures, safeguards, and I asked them for their comments. At that time, we did not have two days, we had ten days. At that time, we had several other provisions which, for example, with regard to the mentally retarded and the mentally disabled, since I am a layman when it comes to determining the routes that a mentally retarded child or a mentally disabled child should pursue, I had put in that it would be recognized or referred from a recognized authority and referring specifically to a medical authority. What they did at that point, was distinguish and they said, mentally retarded should seek this course prior to admission to an institution.

Mentally disabled, another course. Those were the types of discussions we had, Your Honor, and then, afterwards, in March, when we published (21) the proposed regulations, we received comments.

Again, I met with the advisory committee and subsequently, we again discussed the situation, it had not been brought to my attention that they objected to them. We even placed, within the regulations here that they had been discussed with the Advisory Committee and approved.

Now, with regard to the entire concept of their change, certainly, as an instrument in the Commonwealth, I am willing to make any changes that are necessary, but

I was directed then by my superior, Secretary Wohlgemuth to implement these regulations, and they were signed off by her and the attorney general.

JUDGE BRODERICK: Prior to receiving this recommendation?

MR. ROTH: Yes, but I am not exactly sure when that recommendation was dated, but I do know, Your Honor, that with regard to the specific regulations in question, they were discussed with the Advisory Committee and the Advisory Committee, for all purposes can advise us and say do this and we may just take that as it is, advice, and not do it, but at the time we talked about the prior hearings, we talked about prior hearings as well as subsequent hearings and how we could effectuate it and make these regulations (22) stand. The committee at that time was very concerned that parents still be able to voluntarily admit or commit their children, so as a result, we continued along the path which I previously suggested, of effectuating these additional regulations.

JUDGE GIBBONS: Well—

MR. ROTH: I'd be more than happy—I'm sorry, Your Honor.

JUDGE GIBBONS: There seems to me to be four problem areas remaining. One is the 48-hour problem. One is the problem of those over 13, but lacking mental ability to exercise judgment. Another is those under 13, who apparently do not even get notice and the fourth one is those over 13. Actually, the three categories of persons and then, with respect to everybody, this 48-hour issue.

With respect to those over 13, only the 48-hour issue remains, I would think.

MR. ROTH: Yes, Your Honor.

JUDGE GIBBONS: That is, if they have mental ability to exercise judgment. What about the others, the under 13's, particularly?

MR. ROTH: The way that was arrived at, Your Honor, the doctors and the Commissioner of Mental Health and Mental Retardation advised me at (23) the time that in their opinion, especially in their medical opinion, the Commissioner is a psychiatrist in mental health, that those aged 13 or younger really were incapable of exercising any type of judgment. I don't necessarily know that that cures it, but—

JUDGE GIBBONS: Don't we need evidence on that?

MR. ROTH: Yes, Your Honor, we can—

JUDGE GIBBONS: Don't you think we would have to hold a hearing and develop some evidence on that?

MR. ROTH: I would be very pleased to have an evidentiary hearing indicating, you know, what types of juveniles are brought into the institutions.

There were several misleading statements, for example, in the two thousand pages worth of interrogatories that we answered. There was a notation that in some instances, a juvenile was institutionalized because he was a runaway. Now, one of the things which has been very difficult, and I am not saying that the state system is not misused, where juveniles who should not be admitted were admitted, I am sure that does occur. However, I don't think it is as vast as it may appear in some of the state (24) facilities and the reason I feel that is because I have

been told that personnel people at the institutions were going through the voluminous charts and it is not unlikely for a patient whose been in a hospital for a year or two years to have a file cabinet of charts, and they literally went through the charts and wrote down what they first saw as the first note with regard to the admission of the juvenile.

So, if they saw something that said "runaway" or "schizophrenic" they may not have put down the entire thing, they may have put down "runaway", things of that sort.

It is very discouraging and, of course, I am apologetic, because it should have been put in a better framework. However, we were trying to gather information to give Your Honors a feel of exactly what is occurring and the number of juveniles that were admitted and the number of those that objected and what procedures are utilized.

There is no argument in this lawsuit that juveniles are being denied a right to treatment. In fact, plaintiffs' comment that they are in fact being granted their right to treatment.

I think an evidentiary hearing would be (25) extremely helpful in connection with showing what kind of procedure occurs, what kind of backup work, if you will, goes into a psychiatrists meeting with parents, with the child and then independent of the child, to determine if the procedures utilized are sound procedures. If they are not, okay, we will change them. But if they are sound procedures and affording a minimum due process for juveniles, then we feel the regulations should remain intact. Now, I am concerned in the sense that I would

like advice from Your Honors as to if we were to hold an evidentiary hearing, exactly whom you would prefer to have representing the institutions. Shall we ferret out individual institutions, shall we have somebody renowned in the field coming in? In other words, I would like to keep the scope of it as narrow as you would like to make the proceedings move as quickly as possible, also.

JUDGE GIBBONS: We could come back to that, but I think you can gather from the thrust of the discussion that we are pretty much committed already to having the case go forward as a class action?

MR. ROTH: Yes, I realize that.

JUDGE GIBBONS: What is your position with respect to the appointment of a guardian ad litem, rather than allowing it to proceed on the basis of (26) a next friend?

MR. ROTH: Your Honor, very honestly, I was reviewing and thinking about this, and it was almost as in my initial motion to dismiss, I had claimed Haverford State Hospital could not be sued because it was not a person within the meaning of Section 1983 of the Civil Rights Act. With regard to the technicality involved, I am really at the court's pleasure. I really do not object to the going through with Mr. Ferleger as a next friend. I certainly do not want to impede the progress of the lawsuit.

By the same manner, I certainly do not assert that we are wrong, but I certainly would like to get to the merits of this lawsuit.

JUDGE GIBBONS: I take it that you have no objection to having either a co-defendant or an amicus designated to represent parents' interests?

MR. ROTH: No, I would appreciate that, Your Honor.

JUDGE GIBBONS: We will hear from Mr. Ferleger now.

MR. ROTH: Thank you, Your Honor, Your Honors, may I ask one question, please?

JUDGE GIBBONS: Yes.

MR. ROTH: With regard to the class (27) action, will that be eventually divided into subclasses, since we are talking of both mentally disabled and mentally retarded, 18-year olds as well as three-year olds?

JUDGE GIBBONS: I think we should discuss subclasses. Before we leave today, we will take that up.

JUDGE BRODERICK: May I ask another question? I just wondered, Mr. Roth, if you had discussed the effect of the decree in the Park Case, as far as this problem is concerned with the mentally retarded, since my recollection is that in the Park Case, there were commitments made by the Commonwealth to provide for a—we will say a pre-commitment hearing, a pre-change hearing and it may well be that the decree in the Park Case could have taken care of at least some of the problems.

I do not say it takes care of all of them.

MR. ROTH: I haven't looked into that as affecting the case, Your Honor, but I shall do so.

JUDGE BRODERICK: One other thing, I think there were regulations that were promulgated in connection with the decree in the Park Case and those regulations, I thought, applied specifically to the (28) retarded

children, rather than those that had some mental disturbance. All right.

MR. ROTH: Thank you.

JUDGE GIBBONS: Mr. Ferieger?

MR. FERLEGER: Good morning, Your Honors.

JUDGE GIBBONS: Don't spend time on the motion to dismiss. I think you have got our drift that this is going to have to go to an evidentiary hearing.

MR. FERLEGER: I will try to get to the point that Your Honors have raised this morning. First, I'd like to say that from the plaintiffs' point of view, this is not a parental right's case, notwithstanding for the moment that courts used these sections that are challenged and welfare agencies and social workers. The law has come a long way since children's rights were always subordinate to parent's rights. We recognize that, but nevertheless isn't it at least an arguable position that parents have some interest in this matter?

Certainly they do and in cases in our society, where parent's interests and children's interests have conflicted in the area of child abuse, child neglect and dependency laws and even in certain school cases, the courts have been very careful to make sure that the due process and other rights (29) of children were protected and that in many cases, children were given the opportunity to have counsel and guardians ad litem for the purposes of protecting their rights.

In this situation, we have here, I'd like to address first very quickly the question of the per curiam opinion in the Dixon Case that Your Honor raised with regard to

whether or not guardian ad litem should be appointed. I am pleased that Mr. Roth is willing to have me prosecute the case as next friend.

At the same time, I would like to note that according to Rule 17(C) of the Federal Rules of Procedure, the court can appoint a guardian ad litem or allow the suit to be prosecuted by a next friend.

JUDGE GIBBONS: Does not 17(C) if you can proceed as a next friend, except in a representative capacity?

MR. FERLEGER: "If an infant or incompetent person does not have a duly appointed representative, he may sue by his next friend or by a guardian ad litem".

Pennsylvania law says that children can choose their next friend. Judge Biggs in the per curiam opinion did not discuss, to my recollection, the details that we have discussed in our brief of Pennsylvania law with regard to representation. I (30) would suggest that if the court wishes to solidify the situation and be sure of th. court's position, that the court might consider transforming me from a next friend to a guardian ad litem in order for me to be under perhaps closer supervision of the court.

In another case, Judge Van Artsdalen, a case that I brought, during a hearing was faced with a situation where a minor was testifying, a minor ex-mental patient.

JUDGE GIBBONS: State defendants do not object to that procedure, and I think we would be more comfortable with it, because there is some question whether we can grant class action treatment, designating one or more of these minor plaintiffs as a class representative with a fiduciary obligation to absent class members. So,

would you prepare an appropriate order, designating yourself as guardian ad litem for one or more of the plaintiffs and, of course, submit it to Mr. Roth for approval, as to form, before you submit it to us?

MR. FERLEGER: Certainly, Your Honor. I will.

JUDGE GIBBONS: All right, now, that being behind us, let's get on to the subclass issues.

(31) MR. FERLEGER: With regard to the subclass issue, Your Honor, in considering both the mental health cases which we have cited which hold that due process adheres in mental health cases and the juvenile cases which have similar holdings for commitments to juvenile institutions, I am struck with regard to subclasses by the fact that there has never been any consideration of subclasses in those cases. With regard to adults as well as children, there are people who are committed to mental hospitals who are not competent, in a loose sense, to understand the proceedings.

I have represented some of them in commitment hearings. There are adults who do not understand the nature of the proceedings and who need counsel present in order to safeguard their rights.

There are juveniles, for example, in Heryford versus Parks, there was a nine-year old feeble-minded boy, Charles Parker who the court ruled needed a guardian ad litem to protect his interests. It seems to me from every juvenile from age one, to age 18, which is where the regulations now go, they need both counsel and a hearing and for younger and incompetent children, a guardian ad litem.

(32) JUDGE GIBBONS: Your point is that insofar as the complaint makes a due process attack on the

state regulations, all class members are in the same position?

MR. FERLEGER: That's correct, Your Honor. I, frankly, cannot see how subclasses can be workable, unless you first have hearings to determine whether or not the 12-and-a-half-year-old knows what he or she is doing or does not know what he or she is doing. I think you need counsel and a guardian ad litem in all cases, especially—

JUDGE GIBBONS: We will permit the action to go forward as a class action, designating a single class at this time, and I would have you prepare a form of order making such a designation, but providing in the order that it is without prejudice to possible designation of subclasses at a subsequent stage in the proceeding.

MR. FERLEGER: Certainly that's the way I understand the rules to provide and I will prepare that.

JUDGE GIBBONS: This is a class action under 23(B)(2), so there is no notice problem.

MR. FERLEGER: That is correct, Your Honor.

(33) JUDGE GIBBONS: Refer to that in the order, please.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: Now, the description of the class will be persons under 18 years of age—

JUDGE HUYETT: 18 and under.

JUDGE GIBBONS: Yes.

MR. FERLEGER: I can read the way we defined it in the complaint. Paragraph 7, the class is defined as

all persons 18 years of age or under who have been or have been admitted or committed to state mental health facilities under the challenged provisions of the state statute.

JUDGE GIBBONS: That sounds all right.

MR. FERLEGER: I omitted the particular mention of Haverford State Hospital, since that's included.

JUDGE GIBBONS: While I think of it, we need an order dismissing Haverford State Hospital and submit such an order, please.

MR. FERLEGER: I can submit an order.

JUDGE GIBBONS: You will make an order, then?

MR. FERLEGER: Yes.

JUDGE HUYETT: Under rule 21, you can (34) do this only by court order, as I understand the rule.

MR. FERLEGER: I would like to address for a moment the question the court has raised with regard to the parents' representatives and then, I would like to talk briefly about the regulations and the plaintiffs' objections to the present regulations.

The major difficulty that I have with the need for a parent representative is that parents are not the only class which commit children under these provisions. There is a large number of children committed by social welfare agencies, by Catholic social services, by county departments of welfare, to mental hospitals. Courts, as well, use the mental health act to voluntarily commit children. I think it is probably the rural county courts that do not want to bother with the hearing, so the judge signs a child into a hospital as a person in locus parentis.

In addition, aunts and uncles and grandparents very often get involved with committing children. I see the possible interest of a group, such as P.A.R.C., in representing parents of retarded children, but I don't think they can be class representative for all the other people in locus parentis who commit children under the Act. It is my feeling that insofar as the state's (35) position has been, at least, up until today, that they are here to protect the parents' rights, as well as the institutions' rights, that I just do not see what additional facts or law the parents' organization could bring, even if they were to be considered an adequate representative.

In the mental health cases that I am familiar with and in the juvenile cases, I cannot recall any instance where parents of juveniles were called in to determine—help determine what due process meant for juveniles and in mental health cases, even in court commitment cases, there is always a petitioner, there is always somebody who wants a friend or relative committed and the courts, it is my feeling, have to determine what due process requires in a sense regardless of what the petitioner feels that it does.

JUDGE GIBBONS: But the difficulty with that, is that unlike the legislative process, where the competing interests are apt to be brought to the decision makers' attention, when you framed the lawsuit by designating a defendant, in designating a defendant, you have designated the source from which we are going to get the information and which we make what amounts to a legislative judgment.

MR. FERLEGER: I do not believe, Your (36) Honor, that a decision, with regard to what due process is re-

quired before deprivation of liberty is a legislative judgment. I believe that's a constitutional judgment.

JUDGE GIBBONS: You can call it a constitutional judgment or you can call it a decision of the lawsuit, but in fact, if we were to make a choice between a 48-hour waiting period and a 10-day waiting period, it would be a legislative judgment.

JUDGE BRODERICK: I would just like to add, Mr. Ferleger, your very argument that you have just made, that the parents and these welfare organizations and institutions have no interest and should not have an interest in this procedure is the very reason why I would want them to be represented, because, as a good advocate, you certainly are pushing for your point here, but I still feel that parents and these organizations should be represented somehow, whether it is as a party or amicus curiae in this matter, for the very reason that what you are attacking here, as I see it, you say it is not a parents' rights case, and you may be right on that statement, but it seems to me, you are saying that parents cannot waive the right to consent to the waiver of a due process hearing, which in effect is (37) what the act provides and what the regulations provide.

MR. FERLEGER: Right.

JUDGE BRODERICK: I do think we ought to get this input from that side, at least to determine whether or not such a decree which we make would infringe in any way on the rights of parents or the rights of these organizations.

MR. FERLEGER: It seems to me on the very question you feel you need that view on, that the Supreme

Court has already held in the juvenile cases that parents cannot waive their children's rights.

JUDGE GIBBONS: You may be right. That may be the way the lawsuit will come out, but nevertheless, there is at least another side to it.

MR. FERLEGER: I certainly would not stand in the way of the court getting the views of anyone that you feel is necessary. I am just not sure who it would be.

JUDGE GIBBONS: Assuming we want to proceed in that direction, do you have any suggestions?

MR. FERLEGER: Yes, in terms of—I don't know who can represent the county welfare departments, except perhaps the present defendants.

JUDGE GIBBONS: Well, the Attorney (38) General's office is here. I would think that any state agency is adequately represented.

MR. FERLEGER: With regard to the mentally retarded, it seems to me that the P.A.R.C. is the only representative I can think of.

JUDGE BRODERICK: Isn't there a similar organization to P.A.R.C. for those that are mentally disturbed?

MR. FERLEGER: Yes. I don't know if it is quite similar. There is an organization called Pennsylvania Mental Health, Incorporated, P.M.H. and Pennsylvania Mental Health has been involved both with the state in various reports and studies. They just had a commission do a study of the whole state mental health system, and I think they may have participated in lawsuits before. I am not certain, but I think the mentally ill, rather than the retarded also would need a representative.

JUDGE GIBBONS: Suppose that we were to designate such organizations as amicus, with the right to participate and examine and present testimony. We would not have to make them parties. Would either side have any objection to that procedure?

MR. FERLEGER: Not, if that's what the (39) court wishes, Your Honor.

JUDGE GIBBONS: My next question is: Can we impose the duty on counsel to approach two organizations that have been discussed or any others that occur to you, I do not want to turn this thing into an electrical anti-trust case or something, and find out their willingness to participate as amicus, keeping in mind that they will not be parties.

MR. FERLEGER: I am sure Mr. Roth and I can approach them.

JUDGE GIBBONS: You also mentioned some representative of social agencies.

MR. FERLEGER: Catholic social services I know is one that participates as well as various county welfare departments. I am not certain and maybe we can find out, whether there is some association of welfare agencies. I would guess that there is.

JUDGE GIBBONS: Certainly, we would be more comfortable having such agencies participate, at least as amicus, because what we have in mind is that you have already achieved—I don't know whether the state would have moved in this direction anyway—but you have already achieved substantial progress with regulations and asking us to go further is asking a lot. (40) We want to be sure we are on sound ground from everyone's point of view.

MR. FERLEGER: I would like to address the regulations for just a moment, Your Honor. The 48 hour provision of the regulations is not what it seems. Within the 48 hours after an objection by a child over 13 years old, the mental hospital has to contact the applicant, the parents or the agency and then begin to get a 406 Hearing, a court commitment hearing. There is no provision in the regulations that the court hearing has to be held within 48 hours, within a week, within a month or within two months?

JUDGE GIBBONS: We realize that. The regulation is saying that the hearing had to be held within 48 hours would not work, knowing the way courts operate.

MR. FERLEGER: In the Lessard Case, the court held that after someone—in order to show somebody dangerous and mentally ill, you need a probable cause hearing within 48 hours and then a full due process hearing within 10 days to 14 days.

JUDGE GIBBONS: We realize that that problem remains, that there may be the need for a two stage hearing procedure.

(41) JUDGE BRODERICK: May I ask a question, Mr. Ferleger?

MR. FERLEGER: Certainly.

JUDGE BRODERICK: With regard to the recommendations of the Task Force that you submitted, would their recommendation, if it had been adopted or if it should be adopted in the future by the Commonwealth, would that give you the protection you think is necessary?

MR. FERLEGER: Yes, Your Honor, Those recommendations, which were by the Task Force on children and

youth to the Advisory Committee, I think there might have been some confusion before, the Advisory Committee on mental health of the Welfare Department decided to reject those recommendations in making their comments to the secretary, but those recommendations, the way I read them, support the plaintiffs and would provide for a pre-commitment hearing.

JUDGE BRODERICK: I think they do and the only thought that occurs to me is that there may well be that the attorney general would be happy to discuss those, to see whether or not they might be willing to adopt them at this stage.

(42) MR. FERLEGER: I would approve of that. I think that would dispose of this lawsuit.

JUDGE BRODERICK: That is what I was hoping that you would say in answer to that.

MR. FERLEGER: The regulations, by only providing for children over 13 to have this opportunity for some due process in my mind do not protect those who need the most protection.

The child over 13, who does not know what a court looks like or does not know what a lawyer looks like or is too incompetent. The child nine years old or five years old, who gets committed, are the ones who need the most protection. They are the ones who need a guardian ad litem and counsel the most.

JUDGE GIBBONS: What is your position about the 13-year-old classification per se? Aside from the fact and I realize that you want to make for those some automatic hearing requirements, but is that a reasonable age decision on the part of the—

MR. FERLEGER: You mean if the procedures and regulations are proper, is 13 years old a reasonable cut off?

JUDGE GIBBONS: The point at which the notice is given to the child and an opportunity given (43) to ask for a hearing, rather than making it automatic?

MR. FERLEGER: To be honest, Your Honor, I am not that certain, because I do not know many children between nine and 13, and I am not sure what their usual capacities are. The oldest child I know is about six. It seems to me that as the court held in Heryford versus Park, you need the full hearing for all ages. I was re-reading Heryford briefly—

JUDGE GIBBONS: Whether or not the child asks for it?

MR. FERLEGER: That's right. In juvenile court, I am not certain whether a juvenile can come into court, and waive, without counsel or a guardian ad litem and waive the right to a hearing before commitment to a training school or reform school.

JUDGE HUYETT: What would be accomplished at a hearing with a child of let us say five years of age?

MR. FERLEGER: Counsel for the child could cross-examine the doctors who are testifying in support of the commitment, could examine the parents and other witnesses, to determine the facts. I mean all these cases to me show extreme caution by courts when fact-finding results in commitment and if a parent comes in, as happened in Pennsylvania and says, "My (44) child sits in front of the television all day and does not do anything and does not have friends and this child is mentally ill, then I think

you need a court and counsel representing the child to show the other side of the story, because there always is one.

JUDGE GIBBONS: Why, a court, necessarily? You see, this is where I tend to part company with you. There are all sorts of administrative procedures that have withstood due process and challenge and while I realize that commitment to a confined place is a very fundamental change in your status, is it necessarily required judicial action, rather than only judicial review?

MR. FERLEGER: Well, I have never seen a case, Your Honor, in which deprivation of liberty in terms of institutional commitment has ever been subject simply to the approval of administrative agencies, rather than courts. In Pennsylvania, masters hold the hearings in some counties in mental health cases, masters who are appointed by the court and make their recommendations to the court. That, to me is still a judicial proceeding and not an administrative proceeding.

JUDGE HUYETT: Masters would be lawyers?

(45) JUDGE HUYETT: There are only so many judges and recently I held a violation of probation hearing that took seven days and these hearings could be rather lengthy and there are only so many judges.

MR. FERLEGER: It could be. When Dixon was decided and the court in the middle district ruled section 404 unconstitutional, the New York Times pointed out that 14,000 patients were in Pennsylvania hospitals unconstitutionally and all those 14,000 people had to be converted to either voluntary commitments or court commitments.

JUDGE BRODERICK: You are not suggesting that because the New York Times said 14,000 that that's the

correct number, because they did not indicate that in the Dixon opinion itself as to numbers.

MR. FERLEGER: The Dixon opinion just discussed the patients at Fairview and in three paragraphs ruled section 404 unconstitutional.

JUDGE BRODERICK: I think that is all they had in front of them in that particular case, but that's neither here nor there.

MR. FERLEGER: It seems to me there wouldn't be all that many hearings required and the hearings that are required are needed and the fact that (46) more judges might be needed is irrelevant.

JUDGE GIBBONS: We can't look at it that way. There is no point in our devising a remedy that will not work. I am much more interested in devising a remedy that will work. The State of Pennsylvania could frustrate any procedure we devise by adopting an assignment of judges to other work and having these things pile up. Now, I would like to hear, when we get to final hearing what's wrong with some sort of administrative hearing, perhaps before doctors, adversary in nature, with a provision for judicial review, if necessary.

It seems to me that that would be functionally and in some respects preferable, because it would be a hearing before an agency that has a greater expertise than the typical judge.

MR. FERLEGER: Your Honor, we cite in our brief a case called Anderson versus Solomon, I believe a three-judge court case in Maryland, challenging the commitment law.

After it was brought, the statute was changed, also similar to the regulations that we have here and the court in ruling on the new law said it continued to be unconstitutional, because a mandatory (47) judicial hearing was not required, because in that case, you only received a judicial hearing if you requested one.

JUDGE GIBBONS: Not required at any stage.

MR. FERLEGER: That is right.

JUDGE GIBBONS: That's a different thing. I am not suggesting that judicial review would be eliminated, because as I understand it, habeas corpus is always available. So there is always the possibility in Pennsylvania of judicial review of whatever is done, but your due process attack is on commitment without hearing first.

MR. FERLEGER: Yes.

JUDGE GIBBONS: What I am suggesting to you is that the due process point might well be eliminated by a provision for administrative level hearing in all cases.

MR. FERLEGER: I understand your position and maybe we can brief that point further at some later point.

JUDGE GIBBONS: It seems to me that that is a more practical road to go down.

MR. FERLEGER: Your Honor, I just want to conclude by noting some of the facts in the (48) Heryford versus Park Case. The statute involved provided for hearings. The statute involved provided things almost similar to the regulations here. They provided that if a parent, for example, wanted a child committed, the parent filed a petition with the D.A. The prosecuting attorney had to file medical histories of the patient—potential patient. The

court had to have a hearing in which the medical evidence was presented even to the court and the 10th circuit struck down that statute for the reason that the child did not have counsel appointed and did not have the right to confront the evidence before a judicial officer.

JUDGE BRODERICK: I can understand that.

JUDGE GIBBONS: That can be afforded in an administrative level.

MR. FERLEGER: It could be, Your Honor. I would very much appreciate the opportunity to address that point, because it sems to be an original one, because in no mental health case that I know of, has administrative bodies been granted the right to decide when people are deprived of their liberties.

It is not final. The possibility of judicial review would always have to remain.

MR. FERLEGER: In that case, Your Honor, (49) somebody would be deprived of the judicial review through a certain period of commitment until the review can be obtained.

JUDGE GIBBONS: Exactly. Well, I think at this point you know what's bothering us and you know what we want to hear at a final hearing.

Submit an order denying the motion—the motion to dismiss and how soon can you be ready for an evidentiary hearing?

MR. FERLEGER: I think it might be best for Mr. Roth and I to discuss what sorts of stipulations we could arrive at. We talked about that a little bit with Judge Huyett in chambers.

JUDGE HUYETT: Maybe we need some type of order relating to the hearing, so we can define the issues and who the witnesses might be and what their testimony would be, so that all of it is controlled and it does not take longer than it need take.

JUDGE BRODERICK: Yes.

JUDGE HUYETT: I could prepare a proposed order and submit it to the three of us for your review.

JUDGE GIBBONS: Yes. Take up the date of the hearing and the scope of the hearing with Judge Huyett who will enter a pretrial order.

(50) MR. FERLEGER: Your Honor, as I understand it at this point, I will prepare and submit to Mr. Roth orders with regard to the class, with regard to dismissing Haverford Hospital as a defendant, with regard to a guardian ad litem and denying the motion to dismiss?

JUDGE GIBBONS: And the amicus matter.

JUDGE BRODERICK: Recommendations as to—

MR. FERLEGER: Right.

JUDGE GIBBONS: What we should do on that, after counsel approach appropriate agencies, have the agencies prepare a petition for leave to participate as amicus with an order attached.

MR. FERLEGER: Right. Thank you.

JUDGE BRODERICK: All right.

JUDGE GIBBONS: Court is adjourned.

(Whereupon, at 11:25 a.m., court was adjourned.)

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley; Steve Gentile; Leslie Levine; Vicki Mathews; Mark Weand, minors, through their next friend, individually and on behalf of all others similarly situated,

Plaintiffs

v.

Haverford State Hospital; Jack B. Kremens, Hospital Director of Haverford State Hospital; Helene Wohlgemuth, Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Defendants

ORDER

AND NOW, this 29th day of April, 1974, upon motions by the parties and argument thereon, and after consideration by this Court, it is hereby ORDERED that:

1. Haverford State Hospital be and hereby is dropped as a party defendant in this action. The com-

plaint heretofore filed shall stand amended by the elimination of Haverford State Hospital as a party defendant.

2. This action shall be maintained as a class action under Rule 23(b) (1) and (2) of the Federal Rules of Civil Procedure on behalf of the class comprised of all persons eighteen years of age or younger who have been, are or may be admitted or committed to mental health facilities in Pennsylvania pursuant to the challenged provisions of the state mental health law (i.e., 50 P.S. §§4402 and 4403). This definition of the class is without prejudice to the possibility that it may be amended or altered before the decision on the merits herein.

3. Pursuant to Rule 17(c) of the Federal Rules of Civil Procedure, David Ferleger, Esquire, Counsel for the Plaintiffs, is hereby appointed guardian ad litem for the plaintiffs and their class and he shall appear for them in this action and maintain it in their behalf.

4. The Defendants' motion to dismiss this action be and hereby is denied.

By the Court,
(s) Daniel H. Huyett
Daniel H. Huyett, 3d, *J.*

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

ANSWER

First Defense

Preliminary Statement

Plaintiffs in this Complaint attack the constitutionality of Sections 402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. 402, 403) which permits the voluntary commitment of persons 18 years of age or under by parents or persons standing in loco parentis. Defendants contend that these portions of the Act as well as regulations adopted in September, 1973, maintain the constitutionality of the attacked regulations and furthermore do not conflict with the Fourteenth Amendment to the United States Constitution.

Second Defense

Defendants admit the allegations contained in Paragraphs 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 24, 26, 29, 33, 41, 38, 39, and 40; admit in part

allegation 22 that Plaintiff Bartley who was discharged on April 1, 1973, did not wish to enter the hospital nor remain and that Plaintiff Bartley was critical of hospital procedures and deny that any hospital procedures are arbitrary or inconsistent with beneficial treatment; admit in part allegation 23 that Defendants knew Plaintiff Bartley planned to go to school and learn a useable trade upon release because Defendants made arrangements for said school and deny that "nothing worthwhile is occurring to him inside the hospital" when in fact Plaintiff Bartley was receiving specialized treatment; admit in part allegation 28 that Plaintiff Levine's parents are divorced, that her father is remarried and living in Florida, that she would like to live with her father, and deny that she was solely committed to the hospital because she does not get along with her mother and sister when in fact she has threatened their lives several times and suffers from a personality disorder; admit in part allegation 32 that Vicki Mathew's parents on November 7, 1972 applied for and received Plaintiff Mathew's discharge from the hospital, that Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations concerning Plaintiff's parents' financial means; admit in part in allegation 34 that Plaintiff Weand did not wish to become a mental patient and has informed Defendants' agents and employes of his desires to leave which occurred on December 1, 1972, that Defendants deny that Plaintiff Weand was admitted because of excess use of drugs when in fact that is part of his problem which is a psychiatric maladjustment; admit in part in allegation 35 that Plaintiff Weand has not been involved with any therapeutic drug program because his condition warrants other treatment programs in which he has participated; admit in part

in allegation 43 that a person over 18 years of age who does not wish to enter a facility may be placed there involuntariiy upon Order of the court pursuant to a petition, notice and hearing mandated by Section 406 of the Act, that Defendants deny that persons under 18 years of age who do not wish to enter a facility may be placed there when in fact adopted regulations of September, 1973 reveal that a juvenile who objects will be afforded counsel and ultimately a 406 hearing; and deny each and every other allegation contained in the Complaint.

Respectfully submitted,
BARRY A. ROTH
MARX S. LEOPOLD
Assistant Attorneys General
ISRAEL PACKEL
Attorney General
Counsel for Defendants

Dated: June 3, 1974

[Certificate of Service omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

C.A. No. 72-2272

KEVIN BARTLEY, et al., individually and on behalf of all others similarly situated, by and through their guardian ad litem, David Ferleger,

Plaintiffs

v.

HAVERFORD STATE HOSPITAL, et al.,

Defendants

FINAL PRE-HEARING ORDER

In accordance with the Court's Order of April 19, 1974, as amended, Plaintiffs and Defendants submit this Final Pre-Hearing Order.

A. STIPULATION OF UNCONTESTED FACTS

1. The Plaintiffs, individually and on behalf of all others similarly situated, seek declaratory and injunctive relief alleging that certain parts of the Pennsylvania Mental Health and Mental Retardation Act of 1966 which permit the commitment of persons eighteen years of age and under to mental health facilities on a different basis than other persons and without notice, hearing, right to counsel and other procedural safeguards conflict with the Due

Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.

2. Jurisdiction is properly conferred upon and assumed by the court. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§2281 and 2284.

3. This action shall be maintained as a class action under Rule 23(b) (1) and (2) of the Federal Rules of Civil Procedure on behalf of the class comprised of all persons eighteen years of age or younger who have been, are or may be admitted or committed to mental health facilities in Pennsylvania pursuant to the challenged provisions of the state mental health law (i.e., 50 P.S. §§4402 and 4403). This definition of the class is without prejudice to the possibility that it may be amended or altered before the decision on the merits herein.

4. Pursuant to Rule 17(c) of the Federal Rules of Civil Procedure, David Ferleger, Esquire, Counsel for the Plaintiffs, was and is appointed guardian ad litem for plaintiffs and their class and he appears for them in this action and maintains it in their behalf.

5. Defendant Jack B. Kremens, Hospital Director of Haverford State Hospital, is sued as representative of the directors of all mental health facilities in Pennsylvania, all of which are under the authority and supervision and regulation of Defendants Wohlgemuth and the Deputy Secretary for Mental Health and Mental Retardation.

6. The questions of law and fact involved are:

a. Are the representative parties, and their class, admitted or committed to Haverford State Hos-

pital and other mental health facilities pursuant to the challenged statutory provisions?

b. Are the representative parties, and members of the class, admitted or committed involuntarily?

c. Do Defendants operate, execute and enforce the challenged statutes?

d. Are the challenged statutes contrary to the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution?

7. Plaintiff Kevin Bartley is a citizen of Pennsylvania, age 16 at the filing of this action, having been born November 4, 1956.

8. Plaintiff Steve Gentile is a citizen of Pennsylvania, age 18 at the filing of this action, having been born March 20, 1954.

9. Plaintiff Leslie Levine is a citizen of Pennsylvania, age 15 at the filing of this action, having been born October 8, 1957.

10. Plaintiff Vicki Mathews is a citizen of Pennsylvania, age 15 at the filing of this action, having been born September 10, 1957.

11. Plaintiff Mark Weand is a citizen of Pennsylvania, age 15 at the filing of this action, having been born June 13, 1957.

12. Haverford State Hospital is a mental health "facility" under Section 102 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. (Hereafter, the "Act"). It receives admissions and commitments of

persons, including Plaintiffs and their class, under said Act.

13. Defendant Jack B. Kremens is Hospital Director of Haverford State Hospital and is charged with supervision and administration of the facility (§§102 and 103 of the Act). It is to Kremens or his delegates that applications for admission, commitment and release must be made. (§§402(b), 403(b) and 403(c) of the Act).

14. Defendant Helene Wohlgemuth is the Secretary of Public Welfare of the Commonwealth of Pennsylvania which department has the power and duty to enforce the Act and to make all regulations necessary and appropriate to the proper accomplishment of the Act and to operate and assign functions to all state facilities. (§§201(2) and 202(a) of the Act).

15. The Defendant Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania has general authority to supervise and regulate mental health facilities within Pennsylvania.

16. Plaintiff Kevin Bartley was committed to Haverford State Hospital on November 30, 1971 under §403(a)(2) of the Act.

17. He was committed by his mother although he did not wish to enter the hospital.

18. Kevin Bartley was, and still is critical of the hospital and believes that some of the hospital's regulations are arbitrary, that the staff played favorites with patients, that unnecessary punishments were imposed for minor rule infractions, and that patients were transferred to locked wards as punishment for mere allegations of wrong-

doing, without hearing or proof. Defendants admit that Bartley was critical as above but deny the validity of his beliefs.

19. Plaintiff Steve Gentile was committed to Haverford State Hospital, allegedly involuntarily, on August 24, 1971, by his father under Section 403 (a) (2) of the Act.

20. Plaintiff Leslie Levine's mother committed her, allegedly involuntarily, to Haverford State Hospital on October 11, 1972, under Section 403 (a) (2) of the Act.

21. Levine's parents are divorced; her father is remarried and living in Florida; she would have (at the time of her commitment and the time this action was filed) liked to have been with her father because she gets along well with him. Every time she visits with her father, her behavior is excellent. Levine's difficulties in relating to her mother resulted in her commitment. Hospital records indicate Levine threatened the lives of her mother and sister and that she has a "personality disorder."

22. Plaintiff Vicki Mathews was committed to Haverford State Hospital, allegedly involuntarily, on August 9, 1972 by her parents under Section 403 (a) (2) of the Act.

23. Plaintiff Mark Weand was admitted to Haverford State Hospital, allegedly involuntarily, on June 23, 1972 by his mother under Section 402 (a) (2) of the Act.

24. Weand did not wish to become a mental patient and has informed Defendants' agents and employees of his desires to leave which occurred on December 1, 1972.

25. Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. §4402) provides as follows: (Those parts which are challenged by

Plaintiffs as unconstitutional are emphasized by underlining [italics])

Section 402. Voluntary Admission; Application, Examination and Acceptance; Duration of Admission.

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) *Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger,* any person voluntarily admitted shall be free to withdraw at any time. *Where application has been made under the provisions of Section 402(a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.*

(d) omitted here.

26. Section 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 (50 P.S. §4403) provides as follows: (Those parts which are challenged by

Plaintiffs as unconstitutional are emphasized by underlinings [italics])

Section 403. Voluntary Commitment; Application, Examination and Acceptance; Duration of Commitment.

(a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:

(1) Any person *over eighteen years of age.*

(2) *A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.*

(b) The application shall be in writing, signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.

(c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, *or after the applicant or his successor has given written notice of intention or desire to remove the detained person.*

(d) omitted here.

27. The only other provisions for civil commitment to a mental health facility provided by Pennsylvania law are:

a. Section 404 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4404, which permitted commitment of persons upon application of third parties (including parents, guardians, individuals standing in loco parentis, etc.) upon application with certificates of two physicians. Because this section was in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution, this section has been declared unconstitutional. *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971).

b. Section 405 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4405, permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than ten days.

c. Section 406 of the Mental Health and Mental Retardation Act of 1966, 50 P.S. §4406, permits involuntary commitment of persons, regardless of age, upon petition to the state court of common pleas, and after hearing and examination. The respondent to such petition has the right to notice of hearing, the right to counsel and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

28. Voluntary patients over eighteen years of age enter facilities under the Act on their own volition and un-

der Section 402 or 403 and may leave and discharge themselves either at any time (Section 402) or upon proper written notice (Section 403). Plaintiffs and their class are denied such entrances and separation from the facility by the challenged portions of these sections of the Act.

29. A person over eighteen years of age who does not wish to enter a facility may be placed there involuntarily only upon the order of a court pursuant to the procedures, including a petition, notice, and hearing, mandated by Section 406 of the Act.

30. The county in which Polk State School and Hospital is located would have had only 33 additional hearings in 1972 for the juveniles who were instead admitted "voluntarily" by a parent or guardian under the challenged portions of the Act. Similarly, Whitehaven State School and Hospital patients would have required only 87 hearings.

31. The tables attached to this Order and numbered 1, 1a, 2, 2a, 3, 3a, 4 and 4a are true and correct statistical summaries of data submitted by Defendants herein, for the purposes of this action, they are accepted as correct. These tables do not reflect all the data given in response to the interrogatories and questionaire.

32. At the June 15, 1973 meeting of the Department of Public Welfare Advisory Committee for Mental Health and Mental Retardation, the committee requested that the Governor's Task Force on Mental Health of Children and Youth consider the rights of children to refuse treatment.

33. The Task Force's report, dated August 6, 1973, of the meeting of July 18, 1973, stated:

It was agreed that any child has a right to know why he was being institutionalized, that he should be given all of the relevant information regarding such a process, that he had a right to participate in the decision making and that he had a right to have somebody speak up for him. When the child's desires and interests conflict with those of the parents, it appeared highly appropriate that the child should be represented by counsel, rather than his parents. . . . Essentially there was agreement that the child's best interests would be served by holding a *hearing prior* to any commitment to an institution, rather than (as has been suggested by the Department of Public Welfare) a review of the circumstances after institutionalization. The principal reasons were:

(1) The Task Force felt that commitment without a hearing and without the safeguards of due process, representation of counsel and fair notice represented an unacceptable deprivation of liberty.

Young people with emotional problems should have the same rights under the law as delinquents. In those cases where juveniles are accused of delinquent conduct which would constitute a crime if committed by an adult, the court's have rules for procedural guarantees derived from criminal law. These may become the rule in a larger variety of cases having to do with "truancy" or "incorrigibility".

(2) The Task Force noted that the reasons for parents seeking institutionalization in a mental health facility for young people are often similar to or the same as reasons why children are brought up on delinquency charges, i.e., young persons may be refusing

parental authority, involved with drugs, not attending school, etc. The path chosen (mental health or delinquency) is often more a matter of the advice given to parents by social agencies, rather than a significant decision about delinquency or non-delinquency of the youth.

Under this direction juveniles would have such procedural guarantees as written notice of the charges in advance with ample time to respond, right to representation by counsel, privilege against self-incrimination, availability of witnesses for confrontation and cross-examination, and the evidence must prove the charge beyond a reasonable doubt.

(3) Disagreements exist among psychiatrists regarding diagnosis and the need for institutionalization. Research has indicated that when adults request subsequent review (even though already institutionalized) that approximately half are discharged. The implication is that persons may be committed when the justification does not exist "beyond the reasonable doubt." A prior hearing at least forestalls the unjustified deprivation of liberty.

(4) When the review process is followed, i.e., after institutionalization, it is recognized that the patient is at a disadvantage:

(a) He may have been subjected to a variety of institutional pressures, to medication, and to treatment which reduces temporarily his capacity to make the best presentation.

(b) The patient can not "shop around" to find a variety of advice and counsel from sources of his own choosing.

(c) A person in an institution, particularly a child or young person, away from his familiar and protective environment for a period of time may become somewhat disoriented and less judgmental.

(5) A young person ought to have the right of the *least drastic treatment alternative*. Before commitment to an institution is decided upon it should be clear that all other alternatives have been explored: outpatient treatment, partial hospitalization, placement in a foster home or some alternative environment.

(6) It is recognized that problem behavior on the part of a young person is often linked to family dynamics. Commitment tends to place the burden for the disturbed behavior on the young person. When a young person is institutionalized, there is rarely an orientation on the part of the hospital to require parental participation in the treatment process. In contrast, outpatient treatment often may require parental involvement.

The Task Force recognized that commitment does not necessarily mean that treatment will take place. In keeping with previous principles of the Task Force the position was taken that commitment should not take place unless there was a guarantee of appropriate treatment.

Recognizing the slow process of the courts, in recommending the use of a prior hearing, it was discussed further that consideration be given to a quasi-legal structure with special expertise to make these decisions. Analogous structures are the Civil Service Commission and the Human Rights Commission.

In summary, it was the essential position of the Task Force that in order to properly safeguard the rights of youth, when there is a question of the need for institutionalization, a prior hearing should be held to adjudicate the matter, with appropriate Due Process safeguards, preferably before a specially constituted quasi-legal body rather than the existing court structure.

B. AGREED STATEMENT OF CONTESTED ISSUES OF FACT AND OTHER CONTESTED MATTERS

1. *Witnesses*

Defendants propose, in addition to those persons named in their earlier submission and listed below, to call as expert witnesses Dr. Derek Miller of the University of Michigan and Dr. James Masterson of the Cornell Hospital in New York.

Plaintiffs' position is that unless the Defendants prove that these persons were unavailable since the Court's Order of April 19, 1974, Plaintiffs object to their naming further witnesses.

Defendants' position is that, in their earlier submission, they stated that they were "attempting to secure other expert witnesses who have been up to this time, unavailable." Thus, they wish to have these two experts testify.

2. *Need for Hearing*

Plaintiffs' position is that there may be factual differences among expert witnesses regarding whether certain legal procedures may or may not be medically therapeutic for juveniles and whether and at what age juveniles may psychiatrically be thought fit to make application for treatment. It is the position of the Plaintiffs that these factual differences are irrelevant and not essential to the Court's determination of the legal and Constitutional questions posed by this action. A memorandum to that effect has been filed.

Defendants object to this in that expert testimony would reveal that there are contested issues of fact which are critical to the legal issues posed by this lawsuit.

3. *Discharge and Readmission Data*

Defendants propose as facts to be agreed upon the discharge date of each named plaintiff and the readmission date of any of the named plaintiffs as well as the petitioner, if any, and the precipitating behavior causing readmission. This information will be obtained from their medical charts.

Plaintiffs object as this is a class action; the discharge dates and readmission data for the named plaintiffs are irrelevant and not essential to determining the legal issues herein. Also, Plaintiffs object that these proposed facts have not themselves been submitted to the Court or to Plaintiffs.

4. *Monetary Liability*

Defendants submit that there is no monetary liability of any Defendants herein. See *Edelman v. Jordan*, U.S. (March 25, 1974).

Plaintiffs object on the grounds that *Edelman v. Jordan* does not eliminate all "monetary liability" by Defendants. That case dealt with equitable restitution of retroactive welfare benefits. Plaintiffs herein, however, do not now seek damages but will, at the appropriate time, seek attorney's fees and guardian compensation.

5. *Data in Interrogatory and Questionaire Replies*

Typed below are a number of paragraphs containing facts and data from the responses to interrogatories and questionaires submitted by Defendants. The language within each paragraph has been agreed to by the parties. There is disagreement on whether these paragraphs alone are sufficient or otherwise admissible. The positions of the parties are given below, followed by the paragraphs in question.

Defendants' Position

Defendants object on the grounds that they are an analysis by the Plaintiffs' attorney of the data collected by Defendants. As such, the Best Evidence Rule precludes such an analysis when the data itself is readily available to the court. Furthermore, since this court, in the instant case, is the trier of facts, only Your Honors are entitled to analyze the data and draw conclusions. We respectfully disagree with Mr. Ferleger's analysis.

Defendants further object to Plaintiffs' use of the analysis without the complete medical record of each patient before the Court. For the sake of administrative ease it is most common for these state facilities and private facilities which responded to Defendants' questionaire to record only the overt act precipitating the hospitalization of the patient without any further explanations. However, in the overwhelming majority of cases involved, the patient is suffering from some further mental infirmity such as mental retardation, which will become quite apparent to the court upon reviewing the complete medical chart of the patient, which we are willing to provide for this Honorable Court.

Defendants object to paragraph 1 below on the grounds that it is misleading to the court. Defendants agree that the records of the patients state these grounds for admission. However, an examination of the total record of each patient would in most instances reveal a further infirmity requiring hospitalization. Furthermore, all patients admitted to Pennhurst, Polk, and Western State Schools and Hospitals are also suffering from mental retardation. Moreover, all those listed from the private facilities mentioned in paragraph 1 have not objected to their hospitalization.

Plaintiffs' Position

Plaintiffs' position is that the paragraphs below contain portions of the responses to interrogatories filed and sworn to by Defendants. These give the Court a fuller context in which to view the grave issues presented in this action.

Plaintiffs have conducted an analysis of the voluminous data presented; Defendants have not. Plaintiffs have no objection, of course, to the Court's accepting as part of the record the full responses to the interrogatories and questionaires. It is for the convenience of the Court and the parties that these paragraphs are submitted for stipulation.

However, the present suggestion of Defendants that "the complete medical record" of hundreds or thousands of patients be dragged into court is ludicrous and untenable. We suggest the Court rely on the data which the Defendants were ordered to produce and which they agreed to produce.

The very reason why the short explanations in the interrogatory replies are the matters essential to the Court

is given in the Defendants' own words: THE REPLIES: "record only the overt act precipitating the hospitalization of the patient . . . ." The point of this action is that the "overt act" is a factual question which must be decided at a judicial hearing rather than decided by parents or agencies with often adverse interests or by medical personnel. In this light, the medical record amassed *after* admission is irrelevant.

Of course, many institutionalized persons have emotional problems or are retarded—this is also true for non-institutionalized persons. The issue before the Court, is the process for initiating institutionalization procedures and the crucial aspect is the factual situation which sparked the process and the procedures which flow therefrom.

Defendants state they "agree that the records state these grounds for admission." There is no reason to bar from the record these matters.

Defendants' Position on Private Facilities Mentioned

Defendants admit to paragraphs 5, 6, 7, 8 below. However, the state only licenses private facilities and does not supervise these facilities in the same way that they supervise the state mental hospitals and state schools and hospitals. Consequently, the state cannot be held liable should a private facility [be] in violation of the Mental Health and Mental Retardation Act of 1966. The injured party may bring a lawsuit against any such private facility.

Plaintiffs' Position on Private Facilities Mentioned

Regarding so-called private facilities, Defendants attempt to claim that they are somehow not involved and do not supervise them. This is absolutely incorrect.

The Defendants have the power to regulate all facilities, 50 P.S. §4102, and have exercised that power by promulgating *regulations for the private licensed facilities* which require:

> Admission and commitment of patients shall be in accordance with the Mental Health and Mental Retardation Act of 1966 and shall be accomplished by the use of forms developed by the Department pursuant to that Act.
>
> DPW Regulations Title 9100.

Defendants' Position on Paragraph 8

Defendants object to paragraph 8 below on the grounds that it is irrelevant to the issue at hand. This paragraph does not relate to the constitutionality of the statutes involved, but rather, discussed alleged violations of the statute by private facilities which are not under the state's direct control.

Plaintiffs' Position on Paragraph 8

This paragraph demonstrates how the rights of the class here are violated by facilities which, while subject to the mental health act, determine to ignore the law. Defendants are responsible for the licensing and supervision of these facilities yet do nothing to stop their unconstitutional behavior in admitting and committing juveniles without a hearing and without even following the procedures supported by defendants.

1. Children have been institutionalized in Pennsylvania mental health facilities for the following reasons as noted by the institution. The number following the name of the institution is the facility's patient number.

Runaway, incorrigible (Pennhurst #402)

Violent episodes (Polk #13,173)

Hostile, attacked children, attempted to set home on fire (Polk #13,077)

Robbed gas station (Mental Health Center of Carbon, Monroe, Pike Counties #M-0-0543)

Stole truck, car (Mental Health Center of Carbon, Monroe, Pike Counties #M-0-1210)

Member of gang which participated in robbery (Thomas Jefferson University Hospital #360233)

Stealing (Northwestern Mental Health Center #628)

Involved with altercation with ten year old girl whom he chased and struck (Allentown State Hospital #25380)

Firesetting (Northwestern Mental Health Center #620)

Delinquent behavior (Northwestern Mental Health Center #637)

Firesetting (Northwestern Mental Health Center #61)

Arson (Fairmount Farms #16187)

Firesetting, stealing (Western #281)

Runaway (Fairmount Farms #16187)

Runaway, truancy, delinquent behavior (Western #288)

The courts have committed juveniles to these same institutions for similar reasons including the following:

Aggressive behavior toward family. Refusal to attend school. Excessive demands of attention at home. (Western #285)

2. Mental health facilities sometimes cooperate with parents and relatives in doing what Judge (now Chief Justice) Burger, in a dissenting opinion, calls "farming out their kindred into mental institutions for motives not always worthy." *Kent v. United States,* 401 F.2d 408, 416, footnote 4 (D.C. Cir. 1968).

3. Children have wound up at institutions for the following reasons, in addition to their being mentally retarded:

Interim placement while family was on vacation (Polk #13,212)

A mother placed her child at Western because "father out of household in the military." (Western #144)

Hyperactivity interfered with the routine of household and disturbed family members. (Western #15)

A newly widowed father was able to place a youngster at Western because he was allegedly "unable to care for child." (Western #67)

Western accepted another child from a mother because of "desertion of father". (Western #131)

In another case, a mother and a father who themselves had emotional difficulties institutionalized their child because they held the "problems of the child . . . responsible for their emotional adjustment." (Polk #12,-82)

One institution accepted a juvenile because "difficult to care for Loretta and her presence confines the parents in the home." (Western #73)

A boy named Joseph left "no free time for mother . . ." (Western #13)

Family problems (Philhaven #5647)

Family conflicts (Institute of Pennsylvania Hospital #94-94-33)

Family problems, needed separation from the family (Western State, no number given)

Unmanageable at home, attitude of bold indifference, resents all discipline, compulsive eating (Allentown State Hospital #25741)

Problems with family (Philhaven Hospital #5692)

Began to have trouble handling his anger and hurt feelings towards his parents. Took these feelings to school with him. (Allentown State Hospital #25520)

Runaway, conflict with parents (Institute of Pennsylvania Hospital #94-93-74)

Physical burden on mother who has three additional children. (Western #36)

One of three mentally retarded in the family. Coping with this problem is simply too much for the family. (Polk #13,103)

Because argumentative and wanted to stay out of school. Patient's mother overdosed and was hospitalized. Patient then had to be hospitalized. (Warren State Hospital, no number given)

Neglect, Social Deprivation (Stillmeadow Home for Exceptional Children #1138)

Neglect, unstable home environment (Stillmeadow Home for Exceptional Children #1138)

Mother has tuberculosis (Western #129)

Emotional instability of mother (Western #127)

Hospitalization of mother is apparent reason for admission (Polk #11,985)

No serious behavior problem; admitted due to parents' inability to provide a satisfactory home environment (Laurelton #42)

Quite active and destructive. Illegitimate (Western #286)

Sometimes hyperactive. Illegitimate (Western #288)

Illegitimate. Inadequate mother (Western #227)

4. Polk accepted a young boy because "He has no playmates, planned activities, exercise. Presently he does nothing except sit in school and in front of the T.V. at home." (#12836)

5. Three children were committed to mental hospitals because of physical ailments. At Saint Francis' Hospital one child was committed for ulcerated colitis (#13-58-69); another for psychosomatic complaint (#11-81-06); a third was put in the Institute of the Pennsylvania Hospital for weight loss (#94-88-05).

6. There are five children in Saint Francis' Hospital for not going to school. This list is as follows:

school phobic (#12-87-29)
school phobic (#12-80-40)
school phobic (#11-17168)
non-school attendance (#14-18-89)
non-school attendance (#14-57-10)

7. A partial list of juveniles committed for drug related activities is as follows:

Mental Health Center of Carbon, Monroe and Pike Counties:

Overdose (#M-0-1174)
Overdose (#M-0-1165)
Drugs (#Z-0-1004)

McKeesport Hospital:

Medical overdosage (#S.K.)
Medical overdosage (#R.M.)
Medical overdosage (#R.W.)
Medical overdosage (#R.K.)
Medical overdosage (#T.G.)
Medical overdosage (S.C.)
Medical overdosage (T.S.)

Fairmount Farm:

Drugs (#16155)
Drugs (#16147)
Drugs (#16027)

Institute of the Pennsylvania Hospital:

Drugs
(#'s 94-90-72, 94-95-23, 94-93-00,
94-94-92, 94-93-52, 94-91-42,
94-95-32, 94-95-57, 94-95-87)

One juvenile has even been committed for a "*fake* drug overdose." (St. Francis General Hospital #11-85-22)

8. Mental health facilities are required by the Mental Health Act to receive patients *only* pursuant to the statutory provisions of the statute. However, all facilities for which data was provided admitted that, rather than using the proper provisions of the law they accept mentally ill juveniles as "general admissions." This illegal

method of commitment denies to juveniles the presently scant protections of Sections 402 and 403 and also denies them the protection of the new regulations the state has adopted. By going outside the Mental Health Act, the patients' rights (Section 423) need not be endorsed and other rights are denied, e.g., the right to be discharged when treatment is completed (Section 418), the right to leaves of absence (Section 419), the right to review by the Department (Section 420). These are the facilities which presently act in this improper manner:

Happy Hill
Don Fuanella School
Saint Mary of Providence School
Ivy Mansion for Exceptional Children
The Evans School
Clifford Nursing Home
Camp Hill Special School Inc.
Grenwich Home for Children
Refuge Home for Children
Merry Acres
Pleasant Manor Inc.

C. WITNESSES TO BE CALLED AT HEARING

1. *Expert Witnesses of Plaintiff*

1. Henry Kandler, M.D.
Assistant Professor
Einstein School of Medicine
124 E. 84th Street
New York, N.Y. 10028

2. Michael A. Ingall, M.D.
Medical Director
Providence Mental Health Center
355 Broad Street
Providence, R.I.

3. Eli Messinger, M.D.
66 W. 87th Street
New York, N.Y. 10024

2. *Other Witnesses of Plaintiff*

Kevin Bartley
Haverford State Hospital
Haverford, Pa. 19041

3. Plaintiffs' expert witnesses will testify (if the Court determines that it wishes to hear such expert testimony) regarding their experience in psychiatry, and in the treatment of juveniles, that parents and agencies often abuse their authority to commit without a hearing, that hearings would not be anti-therapeutic for juveniles, that there is no psychiatric justification for prohibiting juveniles from personally applying for admission voluntarily.

4. Evidence to be given by Kevin Bartley will include the manner of his commitment to Haverford State Hospital and the circumstances surrounding it.

5. *Expert Witnesses of Defendants*

1. Herman Staples, M.D.
24 Green Valley Road
Wallingford, Pa. 19806

2. Levon Tashians, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

3. Mark Forman, M.D.
Medical Director
Child Psychiatry Division
St. Christopher's Hospital
Philadelphia, Pa.

4. Lance Wright, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

5. James Gibbs, M.D.
Director of Child and Adolescent Psychiatry
Sheppard-Pratt Hospital
Baltimore, Md. 21215

6. Barbara Armstrong, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

7. Aaron Smith, Ph.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

8. Jack Kremens, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

6. Defendants' expert witnesses will testify regarding their experience in psychiatry and in the treatment of juveniles, that the current procedure utilized by the State of Pennsylvania is sound and that the best interests of the juvenile would not be served if it would be otherwise.

D. EXHIBITS TO BE OFFERED IN EVIDENCE—AGREED EXHIBITS

1. Plaintiffs' Exhibit 1—Sealed affidavits of two juvenile mental patients, describing the facts of their commitment, previously filed of record.

2. Defendants' Exhibit 1—Questionaire dated May 31, 1973 submitted to all state schools and hospitals and to all state mental hospitals.

3. Defendants' Exhibit 2—Answers to the above Questionaire submitted by all of the respondents (already filed of record).

4. Defendants' Exhibit 3—Act of October 20, 1966, entitled "The Mental Health and Mental Retardation Act of 1966", 50 P.S. §4101 et seq.

5. Defendants' Exhibit 4—Regulations, previously filed of record, adopted by the Department of Public Welfare in September of 1973 governing the commitment procedure of minors under 50 P.S. §§4402 and 4403. These adopted regulations were published in the Pennsylvania Bulletin, Volume 3, No. 37, September 1, 1973.

E. EXHIBITS TO BE OFFERED IN EVIDENCE NOT AGREED UPON

1. Plaintiffs' Exhibit 2—Document entitled "Child's Right to Refuse Treatment," which document is the Report of the Task Force on Mental Health of Children and Youth, requested by the Department of Public Welfare Advisory Committee on Mental Health and Mental Retardation on June 15, 1973 and submitted to said Advisory Committee on August 6, 1973.

2. Plaintiffs' Exhibit 3—Affidavit of Dr. Leon Ginsburg, Dean, University of West Virginia School of Social Work, previously filed of record. Dr. Ginsburg is leaving for South America at the beginning of August, 1974 and will be there at the time of the hearing.

3. Plaintiffs' Exhibit 4—Affidavit of Dr. Joel Finer, Monthaven Mental Health Center, 2804 Third Avenue, Bronx, N.Y. 10455. Dr. Finer will be unavailable for trial in September, 1974.

4. Defendants object to Plaintiffs' Exhibit 2 above on the grounds that it is irrelevant and object to Exhibits 3 and 4 above on the grounds that they are unable to cross-examine affiants.

F. LIST OF DEPOSITIONS AND PORTIONS THEREOF TO BE OFFERED IN EVIDENCE

1. Deposition of Dr. Barbara Armstrong, taken on March 2, 1973. The exhibit attached to this order lists and describes those portions of the deposition which the parties have agreed to be included and those portions agreed to be excluded. The attached exhibit also indicates those portions of the deposition on which the parties are in disagreement as to which portions should be omitted and which included. The basis for these objections and disagreements is a claim by both parties that the portions are irrelevant.

2. Deposition of Dr. Max Sugar, to be taken July 31, 1974 by the Defendants. It is expected that portions to be admitted and to be excluded will be agreed upon by the parties.

G. SEPARATE STATEMENTS OF CONTESTED ISSUES OF LAW

The parties do not agree on the contested issues of law herein. Their separate statements are given below.

1. The Plaintiffs' contested issues of law are:

a. Do the challenged portions of the Mental Health and Mental Retardation Act of 1966, and Defendants' actions in operating, enforcing and executing the same, deprive Plaintiffs and their class of liberty without Due Process of Law in violation of the Fourteenth Amendment to the United States Constitution in that Plaintiffs and their class are detained and incarcerated in mental institutions without:

1. the right to notice;

2. the right to a pre-commitment hearing;

3. the right to counsel and, if indigent, appointment of counsel;

4. the right to present evidence and testimony on their own behalf;

5. the right to subpoena witnesses and documents;

6. the right to confront and cross-examine witnesses against them and those who wish them to enter a facility;

7. the right to independent expert examination and assistance;

8. the right to be involuntarily detained only upon a decision of a judicial officer in a non-emergency context;

9. the right to be involuntarily detained only upon a decision that they are in need of care, treatment or observation, and are dangerous to themselves or others beyond a reasonable doubt;

10. the right to appeal and review, including provision for assistance of counsel and record and transcript without cost if appellant is unable to pay the cost thereof;

11. other procedural safeguards.

b. Do the challenged portions of the Mental Health and Mental Retardation Act of 1966, and Defendant's actions in operating, enforcing and executing the same, deprive Plaintiffs and their class of Equal Protection of the Laws in violation of the Fourteenth Amendment to the United States Constitution in the following manner:

1. The Act creates two classes of admittees or committees who desire to receive mental hospitalization and treatment. These classes are distinguishable only on the basis of age. One class (the juveniles) can receive such hospitalization and treatment only on the application of another party. The other class (those above the age of eighteen years) can receive such hospitalization and treatment upon their own application. There is no adequate state justification for this arbitrary classification.

2. The Act creates two classes of admittees or committees who do not desire to receive mental hospitalization or treatment. These classes are distinguishable only on the basis of age. One class (the juveniles) can be forced to receive such hospitalization and treatment without notice or hearing and with no procedural safeguards of any kind. The other class (those above the age of eighteen years) cannot be forced to receive such treatment without a judicial hearing, notice and other procedural protections. There is no adequate state justification for this arbitrary classification.

2. The Defendants submit that the contested issues of law is whether or not Section 402 and 403 of the Mental Health and Mental Retardation Act of 1966, including regulations adopted September 1, 1974, are violative of the due process and equal protection clauses of the Fourteenth Amendment to the United States Constitution.

The above constitutes the agreements and disagreements of the parties as finalized at a meeting between counsel in Harrisburg, Pennsylvania on July 25, 1974 pursuant to the Order of Court of April 19, 1974, as amended. Although the original Order specified that this final order was to be filed by July 24, 1974, by agreement of counsel, with the concurrence of Judge Huyett, it is being filed on July 26, 1974, by the Plaintiffs in accordance with Paragraph 2 (d) of the Order of April 19, 1974.

Respectfully submitted,
(s) David Ferleger,
David Ferleger, Esquire
Attorney and Guardian Ad Litem for Plaintiffs

July 26, 1974

MENTAL PATIENT CIVIL LIBERTIES PROJECT

Suite 1407, 1315 Walnut Street
Philadelphia, Pa. 19107
215-735-8409

With: Peter Brown
David Norris

EXHIBIT

Portions of Deposition of Barbara Armstrong March 2, 1973, to be submitted to the Court

Portions Agreed upon by Plaintiffs and Defendants:

Noted below, for each page of the deposition, are those portions of the deposition upon which the parties have been able to reach agreement. For these portions, the Court's direction to exclude colloquy and extraneous matters has been heeded, with success.

A second list follows, denoting those portions of the deposition upon which the parties have not been able to reach agreement, even while attempting to follow the Court's instructions.

The following abbreviations are used below: "D" for delete, "I" for include, and "L" for the line of the actual text on the particular page (spaces excluded). The number at the left margin is the page number. Where no lines are indicated, the entire page is deleted or included.

1. I
2. D after L 9
3. D
4. D
5. Disagreed (second list)
6. D
7. D; I only question by Mr. Ferleger
8. D to L 10
9. I
63. I L 15-20
64. Disagreed
65. Disagreed
66. D L 4-7, 22-24
67. I L 17-"Once . . ."-L 20
68. I 8-22
69. D L 10-11
70. I L 6
71. I L 13-16
72. I L 11-18

10. Disagreed
11. Disagreed
12. I to L 13; D L 14; I L 15, 16; D to bottom
13. I L 3-15
14. D to L 2; D L 11, 12
15. Disagreed
16. I L 6-9
17. I L 13-15; I L 22
18. Disagreed
19. D to L 6
20. I to L 6; I L 17-20
21. D to L 17
22. D L 4-9
23. I to L 5
24. I
25. D L 8-17
26. D L 22-24
27. D L 4, 7, 17-20
28. I to L 7
29. Disagreed
30. I L 20-23
31. I
32. D
33. D
34. D to L 13
35. I
36. I
37. D L 5-6, 10-21
38. D L 21-24
39. D L 7-14, 23-24
40. I to 13
73. I L 6-9, 20-24
74. I
75. D L 13-20
76. I
77. D L 16-17
78. I
79. I
80. D to L 8; I from "I would"
81. Disagreed
82. I
83. I
84. D L 21
85. I to L 10
86. Disagreed
87. Disagreed
88. Disagreed
89. Disagreed
90. D
91. D to L 5
92. I
93. D L 3-13, 17-20
94. I
95. D L 21-23
96. D L 1
97. I to L 8
98. D to L 19
99. I
100. I
101. I to L 18
102. D to L 5
103. Disagreed
104. D L 1-5, 7
105. Disagreed

41. Disagreed
42. D to L 17
43. D L 5-6
44. Disagreed
45. I
46. I to L 16
47. D L 1, 19
48. D L 20-24
49. I L 6-14
50. D L 1
51. D L 3-4
52. Disagreed
53. Disagreed
54. I 7-14, 18-24
55. I 1, 8-14
56. Disagreed
57. Disagreed
58. Disagreed
59. I L 1-22; D L 22-24
60. D
61. Disagreed
62. D L 1-2, 20-24
106. Disagreed
107. Disagreed
108. Disagreed
109. Disagreed
110. I L 1-14, 18-24
111. I
112. Disagreed
113. D to L 5
114. D L 18-19
115. D L 9-18, 22-24
116. I
117. I
118. Disagreed
119. I L 13-17
120. D to L 16
121. I
122. I
123. D to L 10
124. D L 24
125. I
126. Disagreed
127. D L 8
128. I

Noted below are those portions of the deposition upon which the parties have not been able to reach agreement. Plaintiffs' and Defendants' selected deletions and inclusions are denoted in separate columns at the right of the page, opposite the corresponding page number.

	Plaintiffs	*Defendants*
5.	D to L 14 D last 3 lines	D to L 14 D last 5½ lines beginning with "I . . ."

10.	I 1-4; D L 5-12; I L 13-15; D to bottom	Irrelevant
11.	D to L 14	D to L 20
15.	I L 5-19	Irrelevant
18.	D	I
29.	D	I
41.	I L 10-22	D L 19-22
44.	D L 2-6; Begin at "do you"; D L 13-21	I
52.	I	Irrelevant
53.	D L 3-6, 21-24	D 21-24
56.	I to L 4	Object
57.	I L 10-24	I 10-21
58.	D L 1	D
61.	I L 4 from "I will" to L 9	I L 5 beginning with "I certainly . . ."- L 9
64.	D to L 21	I L 2-7
65.	D L 4-5	I
81.	I	Irrelevant
86.	I to L 7	Irrelevant
87.	D to L 21	Irrelevant
88.	D to L 22	Irrelevant
89.	I to L 8	Irrelevant
103.	I to L 9	I to L 16
105.	I to L 16	I to L 16; D L 16-20; I L 20-24
106.	D	I
107.	D to L 14; I from "Speaking"	I
108.	D L 3-5	I L 1; D L 3-5; I remainder

109.	I to L 20	I
112.	I	I L 1-8
118.	D L 21-24	Irrelevant
126.	I	D L 14-18

TABLE 1 -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other family Members*	Misc.	Not Given**
[illegible]	341	[illegible]	0	[illegible]	38	0	1	1	1
[illegible]burg	[illegible]1			536	25	0	0	0	0
[illegible]nburg	[illegible]9	2		93	5	1	2	0	4
Cresson	228	2	2***	209	25	3	5	1	0
Selinsgrove	276	1	3	196	7	2	3	0	20
Western	291	3	-	257	7	4	5	11##	5
Laurelton	70	4	3	58	6	0	2	1	0
Whitehaven	159	0	0	123	7	0	2	1	36
Warburg	214	0	3	100	13	3	2	0	0

* "Other family members" include grandparents, uncles, aunts, brothers.
**There is no explanation for the facilities' so frequently leaving blanks in their replies.
***These two persons are transfers from other facilities; they are listed as "voluntary" but no applicant with appropriate legal section is given.
\## These 11 persons' applicants are listed as "Entrustment Agreement."

All entries refer to the number of cases involved.

TABLE 1a -- "VOLUNTARY" COMMITMENTS AND APPLICANT CATEGORY

Name of State School or Hospital	Type of Commitment 402	403	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members	Misc.	Not Given
Dixmont	1								
Allentown	[illegible]3	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Hollidaysburg				50	5	0	1	0	27
		3		2	[illegible]	[illegible]	[illegible]	1	3
Harrisburg (M & R Center				1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Somerset				6	2	3	0	0	0
Torrance									
Philadelphia	[illegible]		[illegible]	[illegible]	0	0	0	0	0
Warren	11		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
EPPI	[illegible]		[illegible]	[illegible]	2	0	0	1	1
Embreeville	[illegible]		[illegible]	15	4	0	0	2	2
Norristown	11		0	20	9	0	0	0	0
Torrance	[illegible]	5	3	19	3	0	0	0	0
Wernersville	21	0		3	0	0	1	2	0
Haverford	13	134	0	?	?	?	?	0	1
Clark Summit	[illegible]	3	0	[illegible]	[illegible]	[illegible]	[illegible]	?	21
Retreat	[illegible]	4	0	1	0	?	?	?	197
Eastern	211	[illegible]	5	3	0	[illegible]	0	0	1
Harrisburg St. Hosp.	8	7	0	?	?	?	1	0	0
Danville	22	1	0	7	2	0	?	?	215
Mayville	0	1	0	17	5	0	1	4	1
				0	0	1	0	0	1
	4	35	0	34	0	5	0	0	0

TABLE 2 -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School and Hospital	Type of Commitment 406	Not Given**	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members*	Misc.	Not Given**
Polk	18	0	0	1	7	9	0	1[a.]	0
Ebensburg	12	?	?	?	?	?	?	?	12
Pennhurst	44	3	3[b.]	34	4	1	0	0	11
Dresson	?	0	0	0	0	0	0	0	0
Selinsgrove	3	0	0	2	1	0	0	0	0
Western	5	0	6[c.]	2	3	4	0	1[d.]	1
Laurelton	6	0	0	4	1	0	0	1[e.]	1
Whitehaven	?	0	0	0	0	2	0	0	0
Hamburg	20	0	0	16	2	0	2	0	0

* "Other family members" include grandparents, uncles, aunts, brothers.
** There is no explanation for the facilities' so frequently leaving blanks in their replies.
a. The petitioner was the Superintendent of Polk.
b. These were 3 transfers under Section 416.
c. These 6 were under the 1951 law.
d. The County Mental Health Administrator.
e. "Deputy Administrator of Juveniles and Misdemeanants."

All chart entries refer to the number of cases involved.

TABLE 2a -- COURT COMMITMENTS AND APPLICANT CATEGORY

Name of State School or Hospital	Type of Commitment 406	Not Given	Other	APPLICANT FOR COMMITMENT Parent(s)	Welfare or Social Service Agencies	Court, Juvenile Court, Judge	Other Family Members	Misc.	Not Given
Allentown	3	?	?	3	0	0	0	0	0
Hollidaysburg	1	?	?	1	0	0	0	0	0
Harrisburg MH - MR Center			0	0	0	0	0	0	0
Somerset	1	?	?						1
Farview		?	4	0	3	3	0	0	1
Philadelphia	—	?	?						
Warren	26	?	?	0	0	0	0	0	26
EPPI	1	0	0	1	0	0	0	0.	0
Norristown	13	?	?	4	0	1	0	8	0
Torrance	?	0	0	0	0	2	0	0	0
Wernersville	1	0	1	0	0	0	0	0	11
Haverford	3?	0	31	0	0	0	0	0	68
Retreat	1	0	0	0	1	0	0	0	0
Harrisburg St. Hosp.	1?	0	0	3	4	0	0	3	0
Mayview	?	?	?	?	?	?	?	?	?
Danville	6	0	0	?	?	?	?	?	6
Woodville	8	0	0	0	0	7	0	0	1
Eastern	23	0	0	?	?	?	?	?	23
Clark Summit	4	0	0	?	?	?	?	?	4

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TABLE 3

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given
Polk	33	0	0	0
Ebensburg	26	0	0	0
Pennhurst	11	0	30	0
Cresson	41	0	0	0
Selinsgrove	17	2	0	0
Western	55	3	2	0
Laurelton	29	0	2	0
Whitehaven	87	0	2	0
Hamburg	18	0	3	0

•There is no explanation for these omissions in the dat supplied by Defendants.

TABLE 3a

NUMBER OF JUVENILES ADMITTED DURING 1972 TO FACILITIES

Name of State School and Hospital	TYPE OF COMMITMENT 402	403	406	Not Given
Allentown	65	23	2	
Norristown	17	11	15	
Hollidaysburg	0	2	1	
Somerset	{28}		0	
Farview	0	0	0	0
Philadelphia	9	2	4	
Harrisburg MH & R Center	0	1	0	0
Warren	4	0	12	0
EPPI	17	2	1	0
Torrance	0	4	2	0
Wernersville	12	0	3	0
Waverford (to May 1, 1973)	10	113	24	0
Retreat	3	1	1	0
Harrisburg State Hospital	7	13	14	0
Mayview	0	0	0	(1 awaiting transfer)
Woodville	4	29	7	0
Dixmont	0	0	1	0
Eastern	93	0	20	
Embreeville	10	0	10	
Clark Summit	1	1	2	
Danville	21	0	11	

TABLE 4

OBJECTIONS TO TREATMENT*

Name of State School and Hospital	Objected at or after Commitment	Capacity to O Yes	No
Polk	0	--	--
Ebensburg	3	Remarks on r	
Pennhurst	0	--	--
Cresson	0	--	--
Selinsgrove	16	16	0
Western	15	6	8
Laurelton	7	3	4
Whitehaven	0	--	--
Hamburg	0	0	0

*All the data here are questionable both in terms of their incompleteness and the fact that the replies are frequently qualified by such terms as "no objection on the record" or "don't know."

**The question marks ("?") indicate no reply by the facilities.

The capacity to object is determined solely by the facility without any reported judicial determination of incompetency for that purpose.

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SUMMARIES OF SELECTED PATIENTS

#402

CONFIDENTIAL

This information is privileged and should not be divulged without prior permission of The SUPERINTENDENT PENNHURST STATE SCHOOL & HOSPITAL

Hon. Wm. C. Ferguson

IN THE COURT OF QUARTER SESSIONS OF THE PEACE, OF THE COUNTY OF PHILADELPHIA

JUVENILE COURT

April 4, 1913

Committed to the custody of Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic, 15 years of age, Feebleminded.

Subject to order of Court.

[Seal]

Arthur D. Brown
Pro-Clerk

CONFIDENTIAL

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Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic

ADMISSION OF MINOR

APPLICATION

In the case of ———————— of Phila. ———— 19—.
Received 2/1/10
Admitted Mar. 19/10

STATE INSTITUTION FOR THE FEEBLE-MINDED AND EPILEPTIC
Spring City, Pennsylvania

APPLICATION FOR THE ADMISSION OF A CHILD UNDER TWENTY YEARS OF AGE

To the Board of Trustees of the Eastern Pennsylvania State Institution for the Feeble-minded and Epileptic:

I, the undersigned Secretary, resident of Philadelphia, County of Philadelphia, State of Pennsylvania, respectfully request that my Ward,* named ———————— and aged 12 years, be admitted to your Institution.

(Signed) [Illegible]
Secretary

Let Every Question Be Answered as Fully as Possible

Question — Answer

1. What is the child's name? ————————.
2. What is the date of the child's birth? Sept. 12th, 1897.
3. Where was he born? Philadelphia.
4. Was he born at the full period of gestation? Yes.
5. Were there any extraordinary circumstances attendant upon the delivery? If so describe them. No.

6. Was the delivery natural or instrumental? Natural.
7. Was the child injured during delivery, especially about the head? No.
8. What has been the general health and the bodily conditions of the child? Fair.
9. What is now the general health of the child? Good.
10. Does he walk? Yes.
11. At what age did he begin to walk? About 18 mos. old.
12. At what age was any mental peculiarity first noticed? About 9 years age.
13. In what manner did this peculiarity first manifest itself? In strange actions.
14. Has the child ever had any accident or injury of any kind? If so, describe it fully, stating age at time of occurrence, and what effects if any, remain. Was sunstruck between age 3 & 4.
15. [Illegible] No.
16. [Illegible] —
17. [Illegible] No.
18. [Illegible] No.
19. [Illegible] √
20. [Illegible] √

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21. [Illegible]
22. Is consciousness apparently lost at each attack?

23. Are the attacks increasing in frequency or becoming more severe?

24. Do the attacks occur more frequently by day or night?

25. What is the greatest number of attacks the child has ever had in twenty-four hours?

26. Was the father of the child subject to fits or tuberculosis? No.

27. Was the mother of the child subject to fits or tuberculosis? No.

28. Was there any known pecularity in the family of the father of the child? That is, were any of the grandparents, parents, uncles, aunts, brothers, sisters or cousins blind, deaf or insane, or afflicted with any infirmity of body or mind?

29. Is there any peculiarity in the form or size of the head? If so, describe. No.

30. Is there any infirmity of body, or limbs, any paralysis, or any striking pecularity? If so, describe fully. No.

31. Is he of average size for his age? Yes.

32. Is he active and vigorous? Does he run about and notice things, or is he indolent? Is active & vigorous—Can notice readily.

33. Is he nervous? Yes.

34. How is his appetite? Is he gluttonness? Is gluttonness.

35. What is the state of the sense of taste? Is he particular about what he eats, or will he swallow things without regard to taste? Seems to swallow without regard to taste.

36. Are sight and hearing good? Yes.

37. Is he fond of music? Yes.

38. Does he recognize color? Yes.

39. What color does he know by name? Nine.

40. Does he recognize form? No.

41. Does he notice pictures to distinguish them? No.

42. Does he understand language? To a certain extent.

43. Does he understand a command? At times.

44. Can he do errands? Sometimes.

45. Does he talk? Yes.

46. At what age did he commence to talk? √

47. Is there any peculiarity or defect of speech? If so, describe. Very little.

48. [Illegible] No.

49. [Illegible] [Illegible]

50. [Illegible] No.

51. [Illegible] No.

52. [Illegible] from 1 to 10.

53. [Illegible] Fair.

54. [Illegible] when excited wets his clothing.

55. [Illegible]

56. Can he dress and undress himself? Yes.

57. Can he bathe himself? Yes.

58. Does he use a spoon, or knife and fork? Yes.

59. Can he tie his shoestrings in a regular knot? Yes.

60. Can he do any work; and what kind? Can assist around the house.

61. Does he hide, break or destroy things? Yes.

62. Does he sleep well and quietly? No.

63. Is he obedient? No.

64. Is he passionate, or of good temper? Of good temper.

65. Has he any other unfortunate habits? Is a chronic runaway.

66. How does he amuse himself? With anything—just like a boy.

67. What cause has beeen ascribed for his mental deficiency?

68. Has he had the usual diseases of childhood—measles, scarlatina, whooping cough, etc.? Yes.

69. Has he ever been vaccinated? Yes.

70. Where was the father born? Ireland.

71. What was the general bodily condition and health of the father; was he vigorous and healthy, or the contrary? Vigorous & healthy.

72. Were all his senses perfect? Yes.

73. Was he always a temperate man? No.

74. About how old was he when the child was born?

75. If dead, at what age did the father die, and of what disorder?

76. Where was the mother of the child born? Ireland.

77. What was the general bodily condition of the mother of the child; strong and healthy, or the contrary? Strong & healthy.

78. Were all her senses perfect? Yes.

79. Was she always a temperate woman? Yes.

80. About how old was she when the child was born?

81. How many children had she before the aforesaid child was born? One.

82. How many since? Five.

83. How many have died, and of what disease? Two—No information.

84. Was there, or is there, any deformity of body, or mental deficiency in the other children? If so, describe fully. All are normal.

85. What was the state of the mother's health during the time she was pregnant with the child? Good.

86. Was she subject to any bodily injury or severe sickness, or to any extraordinary [illegible] emotion or fright, great sorrow or the like? No.

87. [Illegible] No.

88. [Illegible] About 4 yrs. died from [illegible].

[Illegible portion]

94. State fully what estate or property the child has? None.

95. State fully what estate or property the father has? None.

96. State fully what estate or property the mother has? None.

97. What is the father's residence? (?)

98. How long has he resided there?

99. From what place did he remove to his present residence?

100. What has been the father's occupation? Laborer.

101. What is the mother's residence? Deceased.

102. How long has she resided there?

103. From what place did she remove to her present residence?

104. Do the father and mother reside together?

105. Who has custody of the child?

106. What is the guardian's residence?

107. When was the guardian appointed? July 19th, 1905.

108. By what court was the guardian appointed? By Magistrate [illegible].

109. State what amount the parent or parents or legal guardian is or are able to pay? Nothing.

110. Give name and post office address of person to whom correspondence is to be directed?

(Signed) Wm. H. A. Neills
Secretary
Certificate of Magistrate or Judicial Officer
[Illegible]

CERTIFICATE OF DIRECTORS OR OVERSEERS OF THE POOR

We, the undersigned, ———— ———— of the Poor for the Poor District of Phila. Pa., hereby certify that we have examined the circumstances of the above-named child and his parents, and find that the said child has the following property and estate, to wit: none, and that his parents have the following property and estate to wit: none. And we further certify that the said child has not an estate of sufficient value to defray the expenses [illegible] of his maintenance in the Eastern Pennsylvania State Institution for the Feeble-minded and Epileptic; and that the parents of the said child are not of sufficient financial ability to defray such expense*; and that the ———— ————of the said child is — able to pay ———— dollars per month towards such expense.

And we further certify that the legal settlement of said child is in the said district.

Witness our hands the 28th day of January 1960.

(Signed) [Illegible]

[Illegible] when properly filled out to be mailed to Henry M. Weeks, M.D. Supt., Spring City, Pa.

CERTIFICATE OF PHYSICIAN

I, the undersigned, certify that I have examined the within named ———— and find that he is by reason of being feeble-minded, incapable of receiving instruction in the common schools of the state, [illegible] bodily health and no contagious disorder.

(Signed) [*Illegible*], M.D.

CAMERON, ELK, McKEAN, POTTER COUNTIES CHILD GUIDANCE CLINIC

October 30, 1971
(b. 1/23/58)

PSYCHIATRIC SUMMARY

is now a powerfully built 13 year 10 month old adolescent who has suffered from a mixed type seizure disorder and mental retardation since surviving a nearly fatal nephritis at age 4 years.

He has been on anticonvulsant medications since that age. He has also been placed on several tranquillizing drugs without notable response (Thorazine, Librium).

was first known to me when he was seen psychiatrically, in another clinic, on 5/21/70 on a school referral.

At that time, residential placement was strongly recommended, but was not carried out.

However, such placement should in no way, be delayed in present circumstances which are marked by very sudden, explosive, rage reactions in which he attacks others and for which he has no recollection.

In one instance this summer, while at camp, it took five persons to restrain .

One of the five, a counsellor, lost several teeth in the process.

On several instances, he has physically attacked his mother who, on one occasion, was saved when a neighbor called dad who, with 17 year old brother, have been able to restrain during his wild rages only because of their combined strength.

In view of the foregoing, it is most urgently recommended that be placed in the Polk State School for the protection of , himself, and of others who might become victims of his unforseeable, sudden episodes of violence.

John T. Pitkin, M.D.
John T. Pitkin
Psychiatric Consultant
Confidential
For Professional Use Only
13 173

CAMERON, ELK, McKEAN, POTTER COUNTIES
MH/MR CLINIC

133-135 North Bennett Street,
Bradford, Pennsylvania 1670

September 15, 1971

PSYCHOLOGICAL EVALUATION

Name: is a 13-7 year old white single male residing with his parents at . He had "nepheritis" at age 4. He receives home tutoring.

Reason for Testing: Parents wish to process papers for Polk State School and Hospital.

Date Tested: September 15, 1971

Instruments Used: Wechsler Intelligence Scale for Children
Wide Range Achievement Test
Bender Gestalt
Vineland Social Maturity Scale

Observations:

related well to the examiner. He was courteous and displayed some social amenities. His physical movements were slow, while no gross physical handicaps were noted. His speech was slow, but was clear and distinct. He understood instructions well and seemed to enjoy the various test items.

Results:

Scaled Scores		*Scaled Scores*	
Information	6	Picture Completion	4
Comprehension	4	Picture Arrangement	2
Arithmetic	6	Block Design	2
Similarities	4	Object Assembly	0
Vocabulary	0	Coding	0

Verbal I.Q. 62
Performance I.Q. 44
Full Scale I.Q. 48

is functioning in the Moderate Range of Mental Retardation. It is to be noted that his verbal functioning is at a higher level. While he has difficulties with abstraction and creativity, he can remember factual material and reason in a concrete manner. His visual figure-ground perceptions indicate organicity. His scores in the Performance tasks were depressed by his slow motor activity.

Wide Range Achievement Test

Reading Level 3.6
Arithmetic Level 4.2

Results from psychologicals done in 1966 indicated reading at 1.3 and arithmetic 1.8. It seems that has been able to benefit from his home tutoring.

Vineland Social Maturity Scale, with his mother as informant, estimated a social age around 9.0. He does well with self-help skills, but lags behind in socialization and any remunerative or creative tasks.

David Lee
Confidential
For Professional Use Only
13 173

CREDIT REPORT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF INSTITUTIONAL CORRECTIONS

Date: 12/20/71

Institution: Polk State School & Hospital
Patient's Name:
Legal Residence:
Street & Number:
City or Town:
County & State: McKean County, Pa.
Patient's Number: 13,173
Birth Date: 1/23/58
Veteran Yes ☐, No ☐; Vet. Serial No.
Dependent of Vet. Yes ☐, No. ☐; Vet. Claim No.
Admission Date: 12/20/71
Soc. Sec. No.: RA will apply
Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A":

Marital Status: Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Number of Children:
Wife or Husband's Name & Address:
Patient's Parents:
Name: Father: ; Street No.: ; Address: ; City and State: ; Social Security No.: 208-20-5908; Deceased Date:
Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No: 188-22-9341; Deceased Date:
Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐
Name: ; Street and Number: same as above; City and State:
Legally Liable's Employers Name and Address: ; Weekly Salary:
Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)
Insurance Company Name: ; Address: ; Health: ; Life: ; Other: ; Amount:
Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☐ (4) Son's or Daughter's ☐
Type: ; Address: ; Owner's Name: ; Value:
Personal Property: Stocks ☐ Bonds ☐ Savings and Checking Account ☐ Mortgages ☐ Other ☐ (Explain):

Signatures:
Person Interviewed: ; Relationship: mother & Father; Date: 12/20/71; Interviewer and Date: Charles R. Bruner, Revenue Agent

A. Eligibility: ; Classified: Part Pay; Date: 12/20/71; Revenue Agent: [Illegible]

13 173

Street City

Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)

Send all correspondence to:

Father signed Part Pay agreement 12/20/71 for $17.00.

13 173

Nov. 26, 1971

APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY

Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☒ Voluntary Admission (Complete Parts I and III)

☐ Voluntary Commitment (Complete Parts I and IV)

☐ Emergency Detention (Complete Parts I, V and VI)

☐ Medical Certification (Complete Parts I, II, VI and VII, if patient is mentally retarded also complete Part VIII)

To Be Completed by Facility

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: Decenber 20, 1971

Case Number: 13,173

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):

Maiden Name:

Aliases:

Social Security No.:

Address (Street, Town, State): Pa.

Sex: ☒ Male; ☐ Female

Age on Admission: 13

Date of Birth: Month: 1; Day: 23; Year: 1958

Education: (Enter highest grade completed inc. college & advanced study):

Marital Status: ☐Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☒ Never Married

Occupation: None

Income (Total gross annual family income to nearest thousand dollars): $——

Number of Persons Dependent on Income:

Previous Psychiatric Service:

☒ None

☐ Pa. State Mental Hosp. (24 hr. care)

☐ Private Mental Hospital

☐ VA Hospital

☐ Pa. State Mental Retardation Facility

☐ Psychiatric Unit General Hosp.

☐ Other Inpatient Care

☐ Psychiatric Day-Night Care

☐ Private Mental Retardation Facility

☐ Private Psychiatrist

☐ Outpatient Clinic

☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

Name, Address and Relationship of Responsible Relative:

Telephone No.:

Date: 11-23-71

_____

Signature of Applicant

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths.

(Only Required for Medical Certification Admission)

State of _____)
) ss
County of _____)

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this — day of _____ A.D. 19—.

_____

(Signature of Applicant)

I certify that the signature to the foregoing petition is genuine.

_____

Signature of Person Administering Oath

13 173

PART III.

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

_____

(Patient's Name)

I hereby make application for voluntary admission to Polk State School and Hospital for ☐ myself ☒ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

_____

Signature of patient or applicant

11-23-71
Date

Father
If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

13 173

13173

12,560

McKEAN COUNTY

Admitted 12-20-71

Filed: 11/16/71
Accepted: 11/16/71
For Admission: 12/20/71

POLK STATE SCHOOL AND HOSPITAL

I-21

PSYCHOLOGICAL EXAMINATION

Name: ; Birthdate: 1/23/53; No. 13,173

Admitted: 12/20/71; Examined: 12/30/71; Psychologist: H. W. Lamb

Practical Knowledge: Fair

Psychometrics:

Date: 12/30/71; Kind: SIT; CA: 13-11; MA or SA: 9-2; IQ or SQ: 66; Status & Degree of Retardation: ; Code

Date: 12/30/71; Kind: Raven; CA 13-11; MA or SA: 10-9; IQ or SQ: 77; Status & Degree of Retardation: Mild; Code

Date: 12/30/71; Kind: WRAT: Reading 4.4; Arithmetic 3.9

Date: 12/30/71; Kind: Bender-Gestalt: PMA 8-0

Projectives:

Date: 12/30/71; Kind: Rorschach; Qualifying Personality Reaction: ; Code

Date: 12/30/71; Kind: Hand Test; Qualifying Personality Reaction: without qualifying phrase; Code

PSYCHOLOGICAL IMPRESSIONS

——— is a convulsive young man 13-11, who is dangerously assaultive and it is not clear to what extent his behavior reflects his moods, possible psychomotor seizures, or bullying. He also uses drugs to control seizures. His outbreaks appear to be cyclical and he seems to exhibit more than normal STrength during their course. The Hand Test showed a marked dependency and a possible passive-aggressive orientation, but control appeared adequate and there were no signs of significant pathology.

The Bender-Gestalt Test showed a perceptual-motor age level below his mental level ascertained on intelligence tests, and there were some 'irritable' dots and indications of poor fine control consistent with a convulsive history.

The Rorschach was very unusual and not at all characteristic of mental retardation but contained many confabulations, human movement, contaminations and dysphoric content. The extent to which contaminations and confabulations reflect a psychotic process or simply mental retardation is debatable, but there is a definite aura of schizo-affective tone.

——— behavior is a more serious obstacle to his return to the community than his retardation. He has a combative posture that is easily set off by cyclical tensions paralleling his confabulatory processes and these may trigger psychomotor-like attacks.

13 173

CREDIT REPORT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF INSTITUTIONAL COLLECTIONS

Date: November 18, 1970

Institution: Polk State School

1. Patient's Name:

Legal Residence:

Street & Number:

City or Town:

County & State: Lawrence County, Pa.

Patient's Number: #13,077

Birth Date: 12/13/56

Veteran: Yes ☐, No ☐; Vet. Serial No.

Dependent of Vet.: Yes ☐, No ☐; Vet. Claim No.

Admission Date: 11/17/70

Soc. Sec. No.

Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A"

Marital Status: Single ☒ Married ☐ Separated ☐ Divorced☐ Widowed ☐ Number of Children:

Wife or Husband's Name & Address:

2. Patient's Parents:

Name: Father: ; Street No.: last address; Address: ; City and State: ; Social Security No.: ; Deceased Date:

Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No.: ; Deceased Date:

3. Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐

Name: ; Street and Number: As above; City and State:

Name: ; Street and Number: As above; City and State:

Legally Liable's Employers Name and Address: ; Weekly Salary:

4. Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)

Insurance Company Name: ; Address: Health: ; Life: ; Other: ; Amount:

Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☐ (4) Son's or Daughter's ☐

Type: ; Address: ; Owner's Name: ; Value:

Personal Property: Stocks ☐ Bonds ☐ Savings and Checking Account ☐ Mortgages ☐ Other ☐ (Explain):

Signatures:

Person Interviewed: ; Relationship: Mother; Date: 11/17/70; Interviewer and Date:

A. Eligibility: ; Classified: Indigent; Date: ; Revenue Agent:

13 077

Name Street City

Born: 9/11/52 Married
10/31/54
12/ 5/59
10/16/65
3/ 6/68

Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)

Send all correspondence to:

Also: Mr. Darrell Black, Caseworker

Tenantment Relations Office Housing Authority
Lawrence County
New Castle, Pa.

13 173

APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY

Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☐ Voluntary Admission (Complete Parts I and III)

☐ Voluntary Commitment (Complete Parts I and IV)

☐ Emergency Detention (Complete Parts I, V and VI)

☒ Medical Certification (Complete Parts I, II, VI and VII, if patient is mentally retarded also complete Part VIII)

To Be Completed by Facility

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: Nov. 17, 1970

Case Number: 13,077

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):

Maiden Name:

Aliases:

Social Security No.:

Address (Street, Town, State): 16101

Sex: ☒ Male; ☐ Female

Age on Admission: 14

Date of Birth: Month: 12; Day: 13; Year: 56

Education: (Enter highest grade completed inc. college & advanced study): Special Ed.

Marital Status: ☐ Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☒ Never Married

Occupation: N.A.

Income (Total gross annual family income to nearest thousand dollars): Active Public Assistance

Number of Persons Dependent on Income: N.A.

Previous Psychiatric Service:

☐ None
☐ Pa. State Mental Hosp. (24 hr. care)
☐ Private Mental Hospital
☐ VA Hospital
☐ Pa. State Mental Retardation Facility
☐ Psychiatric Unit General Hosp.
☐ Other Inpatient Care
☐ Psychiatric Day-Night Care
☐ Private Mental Retardation Facility
☐ Private Psychiatrist
☒ Outpatient Clinic √
☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

Name, Address and Relationship of Responsible Relative: Mother

Telephone No.:

Date: October 27, 1970

Signature of Applicant

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths.

(Only Required for Medical Certification Admission)

State of Pennsylvania)
) ss
County of [Illegible])

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this 27th day of October A.D. 1970.

_____
(Signature of Applicant)
Mrs. Shirley Belknap Kerr
Signature of Person Administering Oath
Notary Public
Union Township,
Lawrence County
My Commission Expires Oct. 10, 1974

Commonwealth of Pennsylvania
Department of Public Welfare
MH, MR-1-6/69

PART III.

NA

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

_____
(Patient's Name)

I hereby make application for voluntary admission to

_____
(Name of Facility)

for ☐ myself ☐ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

_____
Signature of patient or applicant

_____
Date

_____
If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

PART IV.

NA

APPLICATION FOR VOLUNTARY COMMITMENT
(Under provisions of Section 403)

_____
(Patient's Name)

I hereby make application for voluntary commitment to _____ for ☐ myself
(Name of Facility)
☐ above named patient. I understand that I must give at least ten (10) days notice in writing to the director if I desire to leave the facility or remove the above named minor patient from facility.

_____
Signature of patient or applicant

_____
Date

_____
If not patient—relationship to patient

Witness

Address of Witness

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parent, or guardian, or other person in loco parentis.

(This commitment is not to exceed 30 days)

PART V.

NA

APPLICATION FOR COMMITMENT FOR EMERGENCY DETENTION
(Under provisions of Section 405)

Application for emergency detention of the patient is hereby made to:

Administrator _____ County

I believe that _____ is mentally
(Name of Patient)
disabled and that immediate emergency detention is necessary.

State your reasons for believing that the patient is mentally disabled (Include the acts or threats which give you reason to believe emergency detention is necessary.):

(Signature of Applicant)

Date

APPROVAL FOR TAKING INDIVIDUAL INTO CUSTODY AND DISPOSITION

(Name of Patient)

☐ Shall be examined by _____
(Name of Physician)
and if required admitted to _____
(Name of Facility)

☐ Shall be admitted direct to _____
(Name of Facility)
for a period not to exceed ten (10) days.

(Signature of Administrator or Delegate)

Date

NOTE: Upon receipt of the approved application and certificate the Director may receive and detain the patient for emergency detention for a period not to exceed ten (10) days.

CERTIFICATE OF PHYSICIAN

[Illegible]

IF PATIENT IS MENTALLY ILL—Admission MUST be made within thirty (30) days of the first certifying examination.

IF PATIENT IS MENTALLY RETARDED—Admission MUST be made within three (3) months of first certifying examination.

FOR EMERGENCY DETENTION — Admission MUST be made immediately after certifying examination.

Name of Patient:

Birth: 12-13-56
Date of Examination: 10-30-70
Address of Patient:

HISTORY OF ILLNESS AS GIVEN BY APPLICANT AND OTHER RELEVANT INFORMATION INCLUDING REPORT OF PSYCHOLOGIST IF PATIENT IS MENTALLY RETARDED

(Form is attached for Report of Psychologist)

Been taken care of by Childrens Hospital in Pittsburgh, Pa since 8 Months old.

I.Q. of 34.—Mental retardation

1967: Surgical [Illegible]

Physical and Mental Findings at Time of Examination:

Physical Complaint: pain in lower walls of [Illegible]

Obesity: 181 lbs.

[Illegible] of legs

Poor coordination of legs—[Illegible] Reflexes knee.

Retarded—childish in response

I certify that I am licensed to practice medicine or osteopathy in Pennsylvania and that I have examined the patient with care and diligence within one week prior to the date of this certification.

In my opinion the patient is:

☐ Mentally Ill
☒ Mentally Retarded
☐ Not Mentally Disabled

(REQUIRED ONLY FOR EMERGENCY DETENTION UNDER SECTION 405)

☐ Patient in Need of Emergency Detention

☐ Patient Not in Need of Emergency Detention

G. S. Cunningham, M.D.
Signature of Physician
16101
Address of Physician

Date: 10-30-70

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths
(Only Required for Medical Certification Admission)

State of Pennsylvania)
) ss
County of Lawrence)

G. S. Cunningham being duly sworn according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

G. S. Cunningham
(Signature of Physician)

Sworn/affirmed to and subscribed before me this 10 day of Nov. A.D. 1970.

I certify that the signature to the foregoing petition is genuine.

Howard B. Hanna,
Signature of Person Administering Oath
Notary Public
[Illegible]
[Illegible]

CERTIFICATE OF PHYSICIAN

IF PATIENT IS MENTALLY ILL—Admission MUST be made within thirty (30) days of the first certifying examination.

IF PATIENT IS MENTALLY RETARDED—Admission MUST be made within three (3) months of first certifying examination.

Name of Patient:
Date of Examination: 10/31/70
Address of Patient: Pa.

HISTORY OF ILLNESS AS GIVEN BY APPLICANT AND OTHER RELEVANT INFORMATION INCLUDING REPORT OF PSYCHOLOGIST IF PATIENT IS MENTALLY RETARDED

(Form is attached for Report of Psychologist)

[Illegible]: I.Q.—34.
History: birth trauma
Physical and Mental Findings at Time of Examination:
Retarded

[Illegible] normal except for obesity—has definite hernia—secondary sex characteristics beginning

I certify that I am licensed to practice medicine or osteopathy in Pennsylvania and that I have examined the patient with care and diligence within one week prior to the date of this certification.

In my opinion the patient is:
☐ Mentally Ill
☒ Mentally Retarded

☐ Not Mentally Disabled

Theodore A. Gravel, Jr., M.D.
Signature of Physician
New Castle, Pa.
Address of Physician
[Illegible]
New Castle, Pa. 16101

Date: 10/31/70

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oaths

(Only Required for Medical Certification Admission)

State of Pennsylvania)
) ss
County of Lawrence)

Theodore A. Gravel being duly sworn according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Theodore A. Gravel, Jr.
(Signature of Physician)

Sworn to and subscribed before me this 10 day of Nov. A.D. 1970.

I certify that the signature to the foregoing petition is genuine.

Howard B. Hanna
Signature of person administering Oath

REPORT OF PSYCHOLOGIST

Patient's Name:
Birthdate: 12/13/56
Date of Examination: 12/23/69

BACKGROUND INFORMATION

MATURATION (Significant lag in growth and development): was a short, obese, 13 year old boy, with an appearance of retardation. He wore glasses and has obvious tongue thrust. He cooperated well until his tasks became more difficult, then he became angry and petulant. His speech was extremely limited, appearing to have a difficult time thinking of names of objects. He frequently made motions to designate the use of the object, or he emitted sounds related to the objects pictured.

——— ——— ☐ over

SOCIAL ADJUSTMENT: ———, a severely retarded boy, at the present time is living with his grandparents. He seems to have been manageable in his mother's home up until a year ago. However, this was accomplished by her occasionally farming her other children to relatives. Mother shows considerable immaturity and inadequacy in handling children; therefore, she was quite uncapable of handling [Illegible].

He attended special education classes in New Castle. This training does not seem to have altered his behavior sufficiently so that he could be maintained at home. The patient's basic problem is one of retardation. In the last year, however, he has begun to "act out" aggressively and is becoming interested in "sex". ☐ over

NAMES OF TESTS AND RESULTS: Stanford-Binet Intelligence Scale Form L-M—earned a mentally 3½ years. For his chronological age of 13, the IQ earned was

34. The range of testing extended from the 3-year level where he passed all of the test items to the 4½-year level where he failed the test items. (NO Tests attempted at higher levels because of his angry response to the pressure of more difficult tasks. It's possible that he could have passed some additional test items.

DIAGNOSIS (AAMD Classification): ———

——— was a severely retarded boy, 13, IQ 34, mental age 3½ years. He was particularly inept in language expression & appeared to have a greater understanding than he was able to communicate verbally. Responded to pressure with infantile anger. Although it was impossible to give him extensive personality testing, he indicated considerable hostility which he has been reported to have released in fire setting & attacks on other children. Emotional control & confused orientation are undoubtedly more of a threat in the home where he experiences more rivalry & opportunity to perform. Placement in a residential (over) DIAGNOSIS, Cont.—center for the severely retarded should be arranged as soon as possible.

Virginia Fulcomer, Ph.D
Clinical Psychologist

Record the Person's Level of Development for Each of the Following:

1. Attribute: Self-Help Skills: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .
2. Attribute: Attentional Development: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .
3. Attribute: Perceptual Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

4. Attribute: Psychomotor Functioning: Severely Sub-Average: ; Moderately Sub-Average: ; Mildly Sub-Average: x; Average: ; Above Average: .

5. Attribute: Communication Skills: Severely Sub-Average: ; Moderately Sub-Average: ; Mildly Sub-Average: x; Average: ; Above Average: .

6. Attribute: Concrete Cognitive Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

7. Attribute: Abstract Cognitive Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

8. Attribute: Vocational Functioning: Severely Sub-Average: ; Moderately Sub-Average: x; Mildly Sub-Average: ; Average: ; Above Average: .

9. Attribute: Personality Integration: Severely Sub-Average: x; Moderately Sub-Average: ; Mildly Sub-Average: ; Average: ; Above Average: . □ over

Virginia Fulcomer, PhD. Clinical Psych.
Psychologist
Mental Health Clinic of Lawrence County

Prepared by:
Louis F. Palumbo
Social Services Director
Lawrence County Housing Authority

LAWRENCE COUNTY
Admitted 11-17-70

Filed: 6/20/69
Accepted: 10/13/70
For Admission: 11/17/70

13077

W.S.S.H.

00015

Reason for placement:

"If ———————— remains for any length of time in this home, I think there is a very good chance of mother breaking down, the marriage ending in separation, father's health failing and the adolescent daughter being pushed into a premature marriage to escape an unhappy home."

Diagnosis (July 20, 1960):

Mental Status: Severe-Idiot I.Q.—10

Diagnosis: Mental deficiency with congenital cerebral spastic paralyses

Cause: Congenital cerebral defect

Somatic diseases: Spastic quadriplegia; Cleft soft palate; Microcephaly; Dental caries

Body condition on admission: Impaired

Behavior disorders: None

00067

Reason for placement:

"Since maternal grandparents have come to live with the family, this has presented serious problems. The maternal grandmother needs constant care but the maternal grandfather has been unable to help and acts as if he hates everyone. The older sister, ————————————, has also had problems in adjusting to the situation. Mother was said to be close to a nervous breakdown and could no longer cope with both ———————— and the maternal grandmother."

Diagnosis (October 1, 1963):

AAMD

Mental Retardation associated with Encephalopathy due to anoxemia at birth

Visual handicap

Hearing handicap

Major motor seizures

Choreoathetosis

Spastic quadriplegic

APA

Chronic Brain Syndrome associated with birth trauma (anoxemia due to cord being wrapped around neck)

Mental deficiency (x^4)—Severe

OO131

Reason for placement:

"It was the worker's impression that this boy was in need of placement because now he has become uncontrollable. The parents realized that at their age they will have increasing difficulty in coping with their son."

W.S.S.H.

00131 (cont'd.)

Diagnosis (December 5, 1963):

AAMD

Mental Retardation associated with mongolism

Level II—Adaptive Behavior—Trainable (?)

APA

Chronic Brain Syndrome associated with pre-natal influence, mongolism, without qualifying phrase

Mental deficiency (x^4)—Severe

00144

Reason for placement:

"The father described her as hyperactive, but the mother disagreed and said that she was only active. Though the parents stated that she was well accepted at home, they felt that now that she is entering pubescence, it will be better for her to be admitted at this time. The maternal aunt who had been caring for her was away and since she was the one against placement, the parents felt that this was the time to arrange for placement. The brothers, though they love ————, are uncomfortable in her presence."

Diagnosis (December 27, 1963):

AAMD

Mental retardation associated with encephalopathy due to anoxemia at birth

Spastic paraplegia

Level II—Adaptive Behavior—Trainable

APA

Chronic Brain Syndrome due to unkown cause without qualifying phrase

Mental deficiency (x^4)—Severe

Re-evaluated diagnosis (March 18, 1974):

AAMD

Trauma or physical agent-perinatal hypoxia

Hydrocephalus, secondary

Spasticity with paraplegia, moderate

Adaptive Behavior-Level III (1973 Revised Classification)

00281

Reason for placement:

". . . she had become a management problem to both her parents and the community."

Diagnosis (August 26, 1964):

AAMD

Mental Retardation due to uncertain cause with the functional reaction alone manifest

Major motor seizures (history)

Level III—Adaptive Behavior

W.S.S.H.

00281 (cont'd.)

Diagnosis (cont'd.):

APA

Mental deficiency, idiopathic, severe bordering on moderate

00288

Reason for placement:

Poor family situation—mother does not get along with patient well. The family is ". . . afraid that the mother would have another nervous breakdown if it (placement) was not done soon."

Diagnosis (September 2, 1964):

AAMD

Mental retardation, cause unknown, with the structural reaction manifest

Hearing and visual handicap

Tremor-head

Level II—Adaptive Behavior—Trainable child

APA

Chronic Brain Syndrome due to unknown cause

Mental deficiency (x^4)—Severe

PSYCHOLOGICAL REPORT

CONFIDENTIAL

For Professional Use Only

Name:

Date of Testing: 7/11/72

Date of Birth: 9/20/61

Chronological Age: 10 years, 10 months

Referred by: The patient's parents

Reason for Referral: Interim short term placement at Polk State School and Hospital during the family's vacation.

Tests Administered: Wechsler Intelligence Scale for Children and the Draw-a-Person Test

Test Behavior:

was extremely cooperative and friendly throughout the complete testing session. He brought his Raggedy Ann doll along with him and related to this doll as if it were possessing human capabilities. , or as he is called , calls this doll Raggy and several times throughout the session asked Raggy if she were comfortable or if she knew what the test answers were. is an affectionate child who goes out of his way to express positive affection and his liking for people. One cannot help but return this affection to him.

WISC:

On this scale achieved a full scale IQ of 54, a verbal 10 of 52 and a performance IQ of 64 which places him in the Mental Defective range of intellectual functioning. The verbal tests ranged in scale score from 0 through 4 with the low scale score of 0 being found on the Comprehension and Similarities subtests. As such, has

extremely defective abilities relating to the ability to evaluate past experiences and to abstract and generalize. The scale score of 4 was found on the [illegible].

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—2—

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The performance tests ranged in scaled scores from 4 through 7 with the low scaled score of 4 being found on Picture Arrangement, Block Design and Coding. The high scaled score of 7 was found on Picture Completion which suggests very high, at least high for this individual, ability relating to visual recognition and differentiation. Even though this child has low intellectual abilities he seems to have developed well within his excellent social and family environment and it can be anticipated that he will develop in the future along these similar lines.

Draw-a-Person Test:

Since indicated a desire to draw he was provided with paper and asked to draw a picture of a person. immediately indicated that he wanted to draw Raggy and proceeded to do such. His difficulty developed in the drawing of legs and he wanted this examiner to draw them for him. When the responsibility was placed upon him he made an attempt and his drawing seems to be at least recognizable of human form. Using the Goodenough Scoring System it was found that has a mental age of 7 years, 3 months which computes into an IQ of 67. This IQ seems to be consistent with the results found from the WISC.

In Summary:

is a child almost of 11 years who has intellectual abilities of a Mental Defective nature. Verbal abilities seem to be low although they do point towards some development and the performance abilities seem to be of a higher nature. During the testing session it was noticed that does have a fairly extensive vocabulary and he is able to combine words into moderate length sentences. Since there is a lack of community facilities which can provide emergency placement it is being recommended that this child be placed at Polk State School and Hospital for a period of 1 to 2 weeks so that the other family members can go on a family vacation. Considering the future it is this examiner's —3— opinion that will be able to continue in the special education programs in the public schools up until the age of 21 and that sheltered workshop placement can be considered from that point on.
should be offered the opportunity for family counseling so that they can provide the best possible educational and vocational experiences for their son.

T. W. Morris
TWM
Coordinator of Mental Retardation Services

TWM:pr

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[Illegible]

Institution: Polk State School and Hospital
Patient's Name:
Legal Residence:
Street & Number:
City or Town:
County & State: Crawford, Penna.
Patient's Number: #13,212

Birth Date: 9/20/61
Veteran: Yes ☐, No ☐; Vet. Serial No.
Dependent of Vet.: Yes ☐, No ☐; Vet. Claim No.
Admission Date: 7/20/72
Soc. Sec. No.:
Medicare: Plan "A" ☐ Plan "B" ☐ Number of days previously used under Plan "A":
Marital Status: Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Number of Children:
Wife or Husband's Name & Address:
Patient's Parents:
Name: Father: ; Street No.: ; Address: ; City and State: ; Social Security No.: 207-22-3626; Deceased Date:
Name: Mother: ; Street No.: ; Address: ; City and State: ; Social Security No.: ; Deceased Date:
Legally Liable: Spouse ☐ Parent ☒ Child ☐ Guardian ☐ Trustee ☐ Committee ☐
Name: ; Street and Number: ; City and State:
Legally Liable's Employers Name and Address: ; Monthly Salary: $685.00
Insurance: (1) Patient's ☐ (2) Parent's ☐ (Check)
Insurance Company Name: ; Address: ; Health: ; Life: ; Other: ; Amount:
Real Estate: (1) Patient's ☐ (2) Spouse's ☐ (3) Parent's ☒ (4) Son's or Daughter's ☐
Type: Frame (5 rm.); Address: ;

Owner's Name: ; Value: $19,500.00
Personal Property: Stocks ☒ Bonds ☐ Savings and Checking Account ☒ Mortgages ☒ Other ☐ (Explain):
Stocks:
Mortgage:
Signatures:
Person Interviewed: ; Relationship: Parents; Date: 7/20/72; Interviewer and Date: Anita Ghering—7/20/72
A. Eligibility: ; Classified: Part Pay; Date: 7/20/72; Revenue Agent: [Illegible]
Born: 12/16/65
Other Remarks: (Any information that was not shown on the reverse side because of space limitations, may be shown in this section.)
Patient was brought to Polk from home in and was accompanied by both parents.
Telephone number of parents:
Correspondence to be sent to:

APPLICATION FOR ADMISSION TO A MENTAL HEALTH OR MENTAL RETARDATION FACILITY
Mental Health and Mental Retardation Act of 1966
(Sections 402, 403, 404 and 405)

Type of Admission

☒ Voluntary Admission (Complete Parts I and III)
☐ Voluntary Commitment (Complete Parts I and IV)
☐ Emergency Detention (Complete Parts I, V and VI)
☐ Medical Certification (Complete Parts I, II, VI and VII. If patient is mentally retarded also complete Part VIII)

To Be Completed by Facility

Name of Facility: POLK STATE SCHOOL AND HOSPITAL

Admission Date: July 20, 1972
Case Number: 13,212

PART I. PERSONAL DATA

Patient's Name (Last, First, Middle):
Maiden Name:
Aliases:
Social Security No.:
Address (Street, Town, State):
Sex: ☒ Male; ☐ Female
Age on Admission: 10
Date of Birth: Month: 9; Day: 20; Year: 61
Education: (Enter highest grade completed inc. college & advanced study):
Marital Status: ☐ Married; ☐ Widowed; ☐ Divorced; ☐ Separated; ☐ Never Married
Occupation:
Income (Total gross annual family income to nearest thousand dollars):
Number of Persons Dependent on Income:
Previous Psychiatric Service:

- ☐ None
- ☐ Pa. State Mental Hosp. (24 hr. care)
- ☐ Private Mental Hospital
- ☐ VA Hospital
- ☐ Pa. State Mental Retardation Facility
- ☐ Psychiatric Unit General Hosp.
- ☐ Other Inpatient Care
- ☐ Psychiatric Day-Night Care
- ☐ Private Mental Retardation Facility

- ☐ Private Psychiatrist
- ☐ Outpatient Clinic
- ☐ Other Outpatient

If patient recently received treatment from an above noted facility and/or physician, please enter name(s):

_____

Name, Address and Relationship of Responsible Relative: [Illegible]
Telephone No.: [Illegible]

_____
Signature of Applicant

Date: July [Illegible]

PART II.

AFFIDAVIT

This affidavit must be sworn to or affirmed before a person authorized to administer oath.

(Only Required for Medical Certification Admission)

State of _____)
) ss
County of _____)

_____ being duly sworn/affirmed according to law doth depose and say that the facts set forth in the above application are true to the best of his knowledge and belief.

Sworn/affirmed to and subscribed before me this — day of _____ A.D. 19—.

_____
(Signature of Applicant)

I certify that the signature to the foregoing petition is genuine.

_____
Signature of Person Administering Oath

Commonwealth of Pennsylvania
Department of Public Welfare
MH/MR-1-10/70

PART III.

APPLICATION FOR VOLUNTARY ADMISSION
(Under provisions of Section 402)

(Patient's Name)

I hereby make application for voluntary admission to Polk State Mental Hospital for ☐ myself ☒ above named patient. I understand that I may leave the facility at any time or may remove the above minor patient from the facility at any time.

Signature of Patient or Applicant

Date: July [Illegible]

Mother
If not patient—relationship to patient

NOTE: If the patient is under 18 years of age, the application must be signed on his behalf by the patient's parents, or guardian, or other person in loco parentis.

CRAWFORD COUNTY

Admitted 7/20/72

Filed: 7/17/72
Accepted: 7/17/72
For Admission: 7/20/72

POLK STATE SCHOOL AND HOSPITAL

I-21

PSYCHOLOGICAL EXAMINATION

Name: ; Birthdate: 9/20/61; No. 13,212

Admitted: 7/20/72; Examined: 7/26/72; Psychologist: H. W. Lamb

Practical Knowledge: Poor

Psychometrics:

Date: 7/26/72; Kind: SIT; CA: 10-10; MA or SA: 5-9; IQ or SQ: 53; Status & Degree of Retardation: ; Code

Date: 7/26/72; Kind: Raven; CA: 10-10; MA or SA: 5-9; IQ or SQ: 53; Status & Degree of Retardation: Mild; Code

Projectives:

Date: ; Kind: ; Qualifying Personality Reaction: without qualifying phrase; Code

PSYCHOLOGICAL IMPRESSIONS

——————— is an educable mongolian boy who should be placed in an educable rather than a trainable program. He is more active than the typical mongolian physically and more alert mentally. He was seen at the Outpatient Clinic by Joseph O'Mara in January, 1966; and at that time he had a social quotient of 60 and was ruling the roost at home. While autonomy for mongolians is questionable, has the capacity to participate in many educable and trainable activities, and an active program appropriate for his active state could keep him functioning at a higher level than is usual for mongolians and might minimize the stigmata and physical characteristics typical of mongolism.

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

No. 72-2272 Civil Action

Kevin Bartley, et al.,
Plaintiffs

v.

Jack B. Kremens, et al.,
Defendants

Philadelphia, Pennsylvania
July 31, 1974

PRETRIAL ORAL EXAMINATION OF DR. MAX SUGAR

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(1) Pretrial oral examination of Dr. Max Sugar, a witness, taken on behalf of the defendants, pursuant to Notice, at 1300 State Office Building, Philadelphia, Penna., on Wednesday, July 31, 1974, commencing on or about 9:33 o'clock A.M., before Marvin Dinter, Official Court Reporter.

Present:

David Ferleger, Esq., Attorney for Plaintiffs.

Barry A. Roth, Esq., Assistant Attorney General, Attorney for Defendants.

Also Present:

Ron Hartman, Law Clerk.

(2) DR. MAX SUGAR, being first duly sworn, was examined and testified as follows:

THE COURT REPORTER: Dr. Sugar, would you please state your full name and address, for the record.

THE WITNESS: Dr. Max Sugar. My address is 3625 Chestnut Street, New Orleans, Louisiana, 70115.

BY MR. ROTH:

Q. What is your profession, please?

A. I am a psychiatrist.

Q. And where did you receive your training?

A. I went to Medical School at the University of Toronto where I got my degree in Medicine and an internship in New Orleans, and I had my residency training in psychiatry and child psychiatry in New Orleans at Louisiana State University and at Tulane University and in New Orleans Child Guidance Clinic.

Q. Are you Board Certified?

A. Board Certified in General Psychiatry and in Child Psychiatry.

Q. Have you written any articles or books?

A. Yes. I have written about 35 articles and I am currently (3) editing a book which will be published this year.

Q. Do some of the articles pertain to child psychiatry?

A. Yes.

Q. Do you have any speciality within the field of psychiatry?

A. Yes, I am a Child Psychiatrist. I also have a special interest in adolescent psychiatry. I have been very

active with the American Society for Adolescent Psychiatry, and I am the immediate past president thereof.

Q. How long have you been practicing?

A. Well, I have been a physician since 1948, 26 years.

Q. And could you indicate what your current position is.

A. I am Clinic Professor of Psychiatry at Louisiana State University in New Orleans, and I am in private practice in New Orleans.

(Whereupon, Mr. Ferleger entered the deposition room.)

MR. FERLEGER: Would you please read back the questions and answers for me, please.

(Whereupon, the preceding questions and answers were read back by the court reporter.)

BY MR. ROTH:

Q. Dr. Sugar, have you been appraised of the two sections of the Pennsylvania Mental Health and Mental Retardation Act of 1966, namely, Sections 402 and 403 which are under attack in this lawsuit?

(4) A. Yes.

Q. Now, the procedure in those sections primarily permit a juvenile aged 15 or under to be voluntarily institutionalized by his parent or guardian or person standing in a loco parentis while adults less than 18 may release themselves.

Also you have been provided with the additional safeguards which are afforded juveniles which, in part, permits notice to be given them for the reasons of their commitment and the accessibility of an attorney in an event a

juvenile, aged 13 or older, objects to his admission or subsequent thereto.

Now, would you, Doctor, reveal, according to your expert opinion, why juveniles should be treated procedurally different from adults.

A. Yes.

I think that in adolescence you still have a person who has not completed their development physically, continuantly, emotionally and their thinking ability and intellectual ability is not developed yet. They don't have the experience of the world and of what goes on as the adult has.

MR. FERLEGER: Did you say adolescent?

THE WITNESS: Yes. I was talking about the youngster between 13 and 18. I was calling that the adolescent.

The adolescent usually has a lot of hormonal changes, secondary sexual changes, growth changes, epiphyseal changes; some of these don't get completed almost until their (5) twenties, so that there is a—this is still a human being that is still needing care, guidance, attention by parents. They are not able to look after themselves. They have an awful lot of unsettled issues, emotionally among other things, so they are still in need of parental care, parental responsibility; and although at times this is difficult in the adolescent years, it should still be available.

Part of the problem comes up early in the adolescent with the adolescent problem about one continuing to be separate and wanting to be away from home and have his own independence and be quite

autonomous and is still unable to do so. He can't make a living; doesn't have a skill or trade or profession, and the only way that the possibilities can be received is through parental responsibility being carried out and allowing the youngster the opportunity for growth and development to the maximum possible form.

In talking about the normal adolescent who has all these things still to achieve, although he is closer to being an adult and is not a child, we still have the same kind of things that go on in terms of need to be taken care of just as with a child, although they are different. The needs are still there.

Now, with an adolescent who has some other things going on, such an intellectual retardation or has problems of an emotional type, he has some special extra needs. Therefore, (6) he may not be in as good a position to judge things as the ordinary adolescent is whose judgment is not that well settled or that good until he has gone through the adolescent period. So, he still is, even more than a normal adolescent, needs parental guidance, responsibility and so on to be continued until he has passed that point and, if he is incapable of functioning, then he needs even more safeguards which are provided by parents, physicians or whatever institution the youngster may need to be placed in for further help.

BY MR. ROTH:

Q. Doctor, with regard to these procedures, the plaintiffs feel that a judicial hearing prior to a juvenile commitment would best serve the juvenile's interest. Could you, please, comment in your professional opinion as to the

effects of a judicial hearing prior to commitment of a juvenile?

A. Yes.

The point at which a juvenile becomes subject to being considered for admission to some kind of psychiatric institution usually is based on his having some kind of obvious symptoms that lead the people around him to become concerned, become aware that something is going on that needs attention. So that this may be awhile or it may be a very short time after the need arises, but there is some problems, something that is erupting, and the youngster needs some help since he is unable to manage it or do something that could be done to settle it, (7) and if he needs professional help, then this needs to be given to him as soon as possible.

Now, when someone has a symptom that brings someone else's attention to it, it is usually because he wants some help.

Now, the adult, if he wants help, can deal with his own mixed feelings about going to the doctor or not going to the doctor or getting to see the dentist or not getting to see the dentist. He has the understanding and the experience of those situations. An adolescent who is disturbed emotionally has not only the problem of the assessment of his need, ordinarily he also has the problem of assessing it in the light of distortions that he has due to his emotional illness, so when someone has somehow impinged on the people around him to the point that they are saying this person needs some kind of help or this person should be off the streets or this person needs to be getting some help, it is because the person who is having the trouble has finally caused enough trouble or enough distress to those around him so that they respond with concern to do something about it.

Now when that happens, the youngster could dissemble and say nothing is the matter and just try to hide it. This doesn't mean that there is nothing the matter. It means he may be upset about the issue of facing the conflicts; it doesn't mean he doesn't want to have some help. It means that he has some mixed feeling about it; so that when finally somebody (8) in society, whether his family or whether it is the police or the school, finally somebody says this youngster needs help and asks something about it, there is usually a feeling of relief on the youngster's part that finally somebody has heard him and someone is going to do something to help him.

He may object, but that isn't unusual in adolescence for a switf turnabout in feelings and attitudes about something; yet if the person who is charged with the responsibility takes that responsibility, there is a lessening of anxiety, a lessening of the panic state. It may be a lessening of feelings of going out of control or doing something destructive to those around him by acting on this appropriately. Then the youngster is placed in a situation where his needs can be taken care of or begin to be taken care of through the proper, professional approaches.

So, if a youngster needs to be placed in a psychiatric institution because he is threatening suicide or because he is out of control or feels he is going out of control, or feels he is in a panic about to do something disastrous, if somebody says that they are going to make arrangements for him to go into the hospital, then there is some feeling of comfort about it because somebody is going to take care of what he needs to be taken care of.

Now, if there is an intervention of a delay this, I think, would perhaps promote the youngster to having some (9) further difficulties instead of having comfort

about being placed in the proper professional situation. He would have the added anxiety of having a judicial hearing instead of treatment, and he would have the added anxiety of putting off getting something done and to be placed in a proper institution.

I would feel that kind of barrier would add to the youngster's difficulties rather than minimize or decrease them.

Q. Assuming there were a hearing, could you see any trauma attaching to the juvenile when present at the hearing?

A. In several ways: first, there would be the delay which I just spoke of, plus the threat of the court which would sometimes stir up a lot of feelings in youngsters, especially about authority and law and incarceration and so on even though the judicial hearing is being held on their behalf purportedly. The youngster may not comprehend this. He is emotionally disturbed or he may have hallucinations or delusions, so you are not dealing with a person who has all his faculties available. We are dealing with somebody who has a disturbance.

If they don't have that they would not be in that position. So you have that to consider also.

You also have the fact that in a judicial hearing, unpleasant facts may be coming up about his behavior, and it is not a treatment situation. It is not a situation where someone is trying to deal with the conflicts. It is a situation where someone is trying to adjudge them and this always brings up the (10) question in a youngster's mind of right and wrong rather than dealing with his conflicts in the professional, psychiatric approach.

So, I would feel that this would be, for these reasons, adding to the youngster's difficulties.

Q. From what you say, Doctor, I assume institutionalization provides at that point—it provides immediate comfort and immediate protection for the juvenile; is that correct?

A. Yes; although the youngster may still espouse hatred of the place or object to it, he is not in a position to really assess it very well, but deep down, emotionally, he is experiencing some relief and as therapy progresses, you often hear them refer to that initial period of admission as being one of relief mixed with some anxiety. There is always anxiety about making a change. Sometimes you get anxiety about the change brought in, but the change in terms of leaving a bad situation for whatever reason, whether it is actually a bad home or whether it is a fantasy or delusion, there will be some concern about the change, but once the change is made there is relief because somebody is listening, somebody is taking care of the need.

If the need can't be taken care of where he is and he is placed in a situation where potentially the need can be taken care of, then there will be relief.

I have had youngsters express this directly when I have suggested that they need to be hospitalized for one (11) reason or another. Then they have responded with "good" or something to that effect meaning they have grasped the idea that I understand their need and that we are going to do something to try to help them and then they feel very relieved about it.

I have had youngsters when I have seen a variety of impulses about to break through. I suggest that we'd better do something about hospitalization. They feel gratified that I have taken a step towards helping them further.

For instance, if a youngster is a potential suicidal or potentially homicidal, it doesn't mean he is going to kill somebody. It means he feels like he might because he feels

like he will go out of control, or if a youngster feels like he is going to embark on a disastrous course, and when somebody finally listens and takes it seriously, then there is appreciable relief.

This is one of the problems, for instance, with youngsters who attempt suicide; that people don't hear them. They don't take notice of the signs. This is one of the areas where psychiatry has been pushing people in responsible positions to take notice of the thing; from the police officers on down to ordinary family members to note that this or that sign indicates that the youngster is asking for help; that he is suicidal and potentially many lives could be saved just by somebody hearing him at the right time and doing something about it.

(12) I had a youngster the other week who had been wearing his hair long. He came in and he had shaved his head completely, which is quite an abrupt turnabout for him. I took this as meaning something pretty serious, and in the course of the inquiry and during that session he started telling me about some illegal behavior that he was about to embark on. We talked about that, and as we talked it became apparent that he was just about to bust his bubble, so he decided he wouldn't do that illegal act, and as we talked further about the potential destructiveness that he was thinking of, he told me of a fantasy that he had the night before of taking a knife and ripping his leg, which I thought was pretty plain evidence that he needed to be in the hospital. I suggested that to him. I tried to get his family to come along and put him in the hospital. He was ready to go.

He just, I thought, should have had somebody to go in the hospital with him which is around the corner from my office.

He said that he would like to go home and pick up his radio and a couple of things.

It ended up where his father just decided that he couldn't get away from his business to come up and take the kid into the hospital, although he was agreeable to the hospitalization.

The hospital said "Fine, send him in."

(13) He ended up at—he went home. He got his stuff. En route he met some other kid and they had some pot and they had a few other things. He ended up going to the park drinking, smoking pot and while in the park with these two other kids, he ended up committing something which a policeman observed and he pulled him in on the basis of an obscenity in public, and he ended up finally getting to the hospital that evening.

He wanted somebody to make sure he got into the hospital. His father wouldn't. His mother wouldn't, but a policeman finally got him in.

He got into the Central Lockup, and the policeman escorted him into the hospital. That's a long way to get into the hospital.

The father's business had come first. If he had said that his son had come first and he needs to be taken care of, he would have gotten into the hospital that morning instead of going through all this business he did the rest of the day.

So, I think, if you follow that brief clinical vignette to sort of illustrate the point that I am making, the trouble could have been avoided 10 hours earlier.

Now, he has his name on the docket for no good reason.

His behavior that afternoon publicly could have been avoided if he had got right in when I spoke to the father (14) and told him he had to go in.

Q. Doctor, I would like you to comment upon statements that have been made regarding feelings in this case. It has been stated that juveniles "Should be afforded a hearing with counsel present to hear evidence in support of the claim that the juvenile is emotionally disturbed and that such a hearing is not traumatic, and it is much more traumatic to institutionalize a child without a hearing."

Now, can you give us your professional opinion as far as a balancing type of test, if you will, with regard to trauma affecting a juvenile prior to commitment or trauma affecting a juvenile if a hearing is not afforded.

A. I think what I have just said in the last few minutes would cover that point.

I also would think if the youngster has his need bypassed as I have just mentioned, he gets more upset instead of somebody hearing him. He needs this professionally, medically. Then he gets what he might construe as another shuffling around.

I think that perhaps the point of having a hearing may be mixed up with sentimentality. Sentimentality doesn't have any place in treatment because what you are dealing with is someone who is ill rather than romantic notions. So, if he is ill, then we start treating him by putting him in a place to take care of him. The hearing should not be put off forever if the youngster wants a hearing. Then you have that as part (15) of the law. Then he can still have recourse to that.

Q. It has also been stated, Doctor, that "Juveniles are institutionalized as mentally ill when their acts may be defined merely as juvenile delinquency."

A. Well, juvenile delinquency is a rather broad term.

Delinquency refers to an act that someone has been caught doing.

Most youngsters commit something illegal at some time. This is part of their growing up and learning right and wrong.

Most youngsters do a little stealing in their early grade school years. They do a little lying. They may break windows and run away and never be caught. You don't call them delinquent. They have never been caught. They committed something they should not have done, but the youngster who continues and doesn't learn right from wrong is having a symptom of some emotional disturbance to whatever degree it is. It is a symptom.

If he is stealing, if he is truant from school repeatedly, running away from home, these are symptoms of something emotional that has gone awry. So, the fact that it may just be a symptom doesn't mean it should be neglected. It may be a symptom of something quite serious. It may be a symptom of schizophrenia. It may be a symptom of a psychosis of another kind. It may be a symptom of something that hasn't gotten quite organized into a specific neurosis, but there is a tendency (16) toward this. It means that there has been some kind of emotional deprivation, very serious at some point in the youngster's life, and this represents his attempt to deal with it emotionally through this behavior.

Behavior has means. If we can understand the meaning of that, we understand something about the antecedent that led up to it. It may have happened 10 years before, but it is still continuing on because it hasn't gotten settled, so there is still a conflict, and the youngster's behavior is looked on as a symptomatic act of this disturbance just like if we have a fever. We know that there is something the matter in the body at that time. There is an inflammatory process. It may be due to infection. It may be due to

physical trauma, maybe malignancy. It means something is going badly someplace in the body physically.

If we have a symptomatic act of disturbed behavior whether it is called a delinquent act or whether it is called a delusion, it is an act or—it is a set of beliefs that are representative of something emotionally disturbing that person.

Q. Are you familiar with the concept enunciated in Ray Gault?

A. Yes.

Q. Doctor, that case reveals in part that "Juveniles who may be tried for a criminal act shall be afforded counsel."

An anology has been made in this case that juveniles were deprived of their liberty for a criminal act or for (17) emotional disturbance or emotionally disturbed behavior should be afforded a hearing prior to commitment.

Can you comment in your professional opinion upon the distinction between juveniles committed for criminal acts versus juveniles committed for emotional disturbances?

A. Well, sometimes you will have juveniles who have committed criminal acts because of emotional disturbances.

Sometimes you have quite a malange of the two, but as I understand that Gault case, that was a case where a youngster had a complaint lodged against him by an adult on a illegal basis and the youngster was going to be sent up to an institution without any further hearing because he was a juvenile.

There was no involvement there of medical process. There was no diagnosis made. There was no assessment of his act made medically.

There was a judicial process, and that link is a somewhat different situation when there is a medical need because the situation of that is quite—since in the hearing of the youngster's act it was adjudged as criminal without a counsel being present; in a medical situation you don't have somebody admitted to an institution just on the parent's say-so or the law officer's say-so.

You have the youngster admitted on the basis of a medical examination. Some psychiatrist has examined him. He isn't just admitted because somebody says that he should be (18) admitted.

If I send somebody into the hospital they are not admitted to the State institution because I say so. They may be presented there, but the admitting physician at the State institution still has to do his own examination, and if he says this youngster needs to be admitted, then they are admitted.

So, there is protection of a youngster because there is professional, medical opinion that is held responsible for the admission.

Q. Do you feel as a professional, of course, that you are satisfied with the voluntary admission and commitment sections of the Pennsylvania Mental Health Act and Mental Retardation—

A. It allows for the youngster's needs to be taken care of medically so he is protected that way.

I think it allows for cases where the youngster has objections to bring him to the attention of the proper authorities to a judicial hearing that is allowed. I think it allows the youngster to get the parental protection and the parental responsibilities brought to their fullest to his needs in this way. So, the youngster is protected, I think. The parental rights are protected and the youngster's rights are protected.

Q. Doctor, do you often testify in court cases?

A. I have in the past. I have not in the last few years.

Q. You have?

(19) A. I have not in the last few years, not at all.

Q. Are you being compensated for your testimony today?

A. Yes.

Q. Are there any other comments you would like to make, Doctor, knowing the nature of this case?

A. Yes.

MR. FERLEGER: I object. I think it is improper to simply ask a question inside a question. If you have a question to ask, you should ask him a question rather than asking for his general comments about the nature of the world.

MR. ROTH: You can note the objection.

The question remains.

Do you have any comments with regard to the regulation or acts involved and your feelings towards them and towards the nature of this case?

THE WITNESS: Yes. I have some other comments to make relative to the last question.

In my view, the way the current law is arranged, the youngster is protected. His needs are taken care of medically. The parental rights are not abrogated, and the due process is available in due time.

I think if he has changed in a way, that is, perhaps being suggested by the action in this case, there is perhaps a danger that the parental protection of the

youngster will be removed which means the State then becomes in charge of the (20) adolescent and raises them and that the law makes the diagnosis instead of physicians.

I think this would be a travesty for the adolescent development and medical care.

Q. Doctor, let me ask you one more question with regard to this case: It has been said that "Institutions are used as dumping grounds by parents for placing their children in institutions for reasons other than children should be placed in institutions."

MR. FERLEGER: It should be noted, for the record, that it is Chief Justice Berger of the Supreme Court who said that.

THE WITNESS: Who said what?

MR. FERLEGER: That "Families use mental institutions as dumping grounds for unwanted members of their families."

BY MR. ROTH:

Q. With all due respect for the reporter, when Mr. Ferleger wishes to cross-examine, he can, and in regard to that statement it also should be noted that that was made in a dissenting opinion by Chief Justice Berger; nonetheless it has been stated that these institutions are used as a dumping ground for parents and the parents farm their children out.

Now, do you know, from your knowledge, personal knowledge and background—would you comment about that?

Perhaps the abuses of the system and why you still (21) maintain that the system, as you know it, in Pennsylvania is sound. Would you comment on that.

A. There are a number of considerations in that. I would think that one of them has to do with the fact that physicians are liable to error just like any other humans. They can make a mistake in a diagnosis. They also may get distortions consciously, or otherwise put into the situation by the parents or by the youngsters so that they don't get a pure picture of the behavior of the symptoms of what has been going on. Those are, I would think, very small in number, and I don't think that is cause enough to change the structure.

I think it behooves us to try to be more meticulous in our diagnosistic assessment and be careful in scrutinizing the situation of each case as it comes up.

Also, I would think that by and large parents do protect their youngsters and do look after them fairly suitably because, as it stands now, we have maybe—well, let's say, roughly 10% of adolescents who are in need of some kind of psychiatric help. I think if it were that parents were not doing a pretty suitable job it might be reverse and it may be 90% would be needing psychiatric care and 10% would be functioning fairly well.

Now, on another point which I think needs to be brought in, there are situations where the family resources are just strained and they are drained and they just can't function (22) with a psychotic child or can't function with a severely retarded child, and even though ideally it might be best to have that retarded or mentally retarded child at home or a psychotic child at home, they just don't have enough resources. They are not capable themselves emotionally to handle the youngster at home, or it may be having quite a deleterious effect on other members of the family, or it may be in some way interfering with the father's being able to attend to his income-gathering pursuits, so that the family may end up on Welfare.

The father has to stay up to restrain a 15-year old boy who is quite actively destructive around the house and protect the rest of the family from his behavior that is undesirable. That means he can't go to work. So, in some of those situations, the total family functioning has to be assessed emotionally on the drain and strain on them.

There are also cases where some people just don't fit into the family scheme; the family is trying to function in one direction and the adolescent is so disturbed he just cannot fit in, and what he is doing is very much against the family function optimum. He needs treatment in a special place.

I would think that those are at times symptomatic of the youngster wanting help and being in a position where he needs to go to an institution to get help. He can't function. He can't fit in with the family for whatever reason.

So, I would think that the question of a dumping (23) ground and an abuse of that sort of thing—I don't know of any statistics that anybody has presented about that kind of thing, but I know from time to time those things have happened.

On the other hand, there are some parents who physically abuse their own children and cause skull fractures and almost kill them sometimes when they are just two or three or four years old and, there are efforts being made to try to curb that and to find those cases and take the child away from the parents because the parents aren't able to look after them properly, but still even in those extreme cases there are a very small proportion of parents, which means that there are situations where parental responsibility is not being fulfilled properly and then someone has to step in and take over.

The diagnosis of those situations is made by the doctor.

The child abuse cases are diagnosed by a doctor, and then the law is brought in to assist in proper placement of the child away from this home; not to hurt the child, but to help him survive.

So, if you take that as an extreme case, there are other cases where the youngster has to be in an institution so he can survive emotionally.

Q. Doctor, with regard to something that could be placed back in your qualifications, are you a member of any associations?

A. Yes.

(24) Q. Could you give us the names?

A. The American Psychiatric Association; The American Academy of Child Psychiatry; The American Society of Adolescent Psychiatry; The American Orthopsychiatry Association; The Southern Psychiatric Association; Orleans Parrish Medical Society; Louisiana State Medical Society; American College of Psychiatrists.

I think that's it.

MR. ROTH: I think that covers it.

I have no further questions.

BY MR. FERLEGER:

Q. Dr. Sugar, I am interested by your comments that the use of the law in mental health situations can sometimes, in your opinion, make the diagnosis, which is to occur, be accomplished by the law rather than by a doctor.

In Louisiana, are there procedures by which adults can be institutionalized in a mental hospital without a prior judicial hearing?

A. Yes. They can admit themselves voluntarily.

Q. Are there procedures for involuntary commitment for adults without a judicial hearing?

A. No. It has to be based on a diagnosis first.

Q. So, in those situations, once a doctor has made a diagnosis, the doctor makes that diagnosis to the Court and then it is a legal question whether or not the person is mentally ill or needs to be institutionalized; is that correct?

A. (25) It's based on the diagnosis given by a psychiatrist.

Q. And the decision is made by the judge?

A. Yes.

Q. So, your position is not that the Court shouldn't at all be involved in the commitment of juveniles, your position is that the Court should rely on or make use of the diagnosis and expert opinions of doctors; is that right?

A. Yes.

Q. Now, in Pennsylvania, except in emergency situations when children or adults could be committed without any delay whatsoever, when an adult is to be committed to a mental institution, the law provides that there be a prior judicial hearing.

Now, is it your opinion that that prior judicial hearing is the kind of sentimentality of the law that you mentioned with regard to children?

A. I don't think I understand your question.

Q. Do you favor, as an expert, a prior judicial hearing before an adult is committed to a mental institution?

A. No. An adult can be committed without that in case of emergency.

Q. Okay.

In the non-emergency situation—

A. Yes.

Q. Do you favor a prior judicial hearing for adults?

A. Not necessarily.

(26) I have seen some rather difficult things for the patient where there was that kind of thing and was very embarrassing, very painful to the patient.

Q. So, there are some non-emergency situations where you would feel, in your expert opinion, that there ought not to be a hearing even for an adult who is going to be committed?

A. Yes, where the adult objects and seeks counsel and wants to have the hearing in that case, this is what the law provides.

Q. Even though in your opinion it shouldn't be necessary?

A. Well, I don't think I was addressing myself to that.

Q. Well, that is the question I am asking you.

Are there situations where an adult needs hospitalization in a non-emergency situation in that kind of circumstance? Do you feel that a prior judicial hearing is appropriate?

A. I think, as I understand it, the judicial hearing in those cases, is utilized to provide admission to the adult because he refuses to accept the recommendation, so, therefore, the law is utilized to implement the diagnosis and the recommendation therefrom. So, I feel, yes, it needs to be utilized.

Q. There are situations, aren't there, where the prior hearing is used in order to incarcerate the person for the purpose of getting a diagnosis; isn't that right? Isn't that what the Pennsylvania law provides?

A. To incarcerate a person, no.

Q. For the purpose—

(27) A. Of making a diagnosis?

Q. For the purpose of obtaining a diagnosis.

A. I would hope that the diagnosis had been made before, and I don't see that that would be a proper pursuit of medicine to have someone incarcerated to make a diagnosis.

Q. Even though that is what Section 406 (a) of the Pennsylvania Mental Health Act provides? Do you think that part is improper?

MR. ROTH: Objection.

THE WITNESS: I don't understand how that comes into what I understand of the Pennsylvania Law.

BY MR. FERLEGER:

Q. Well, the Pennsylvania Law provides, doesn't it, "That a person may be committed involuntarily to a mental hospital by a Court without any diagnosis having been made; that commitment being for the purpose of making a diagnosis"?

Now, I understood your testimony to have been that in your opinion that would be an improper role for the law to play; is that right?

A. My opinion was that the youngster could be admitted.

Q. I am talking about adults now.

A. I thought the case was about adolescents.

Q. My question is about adults.

MR. ROTH: I think you are confusing the doctor in terms of what you are revealing about 406. If you want to give him a little more background, you know, so he is not (28) confused and misled in attempting to answer—

MR. FERLEGER: I will repeat my question.

BY MR. FERLEGER:

Q. Pennsylvania Mental Health—the law provides "That an adult may be committed involuntarily to a mental institution as a result of a judicial hearing prior to there having been any involvement of any psychiatrists or any medical opinion with regard to that person's condition."

That commitment under Section 406 (a) of the Mental Health Act provides for an "evaluation or a diagnosis to be made after that involuntary commitment."

A. I see.

Q. Now, I understood you to have just testified that you consider that kind of commitment or incarceration without a doctor having been involved to be inadvisable; is that correct?

A. No.

I think in that kind of situation, just as I was saying before, somebody makes enough trouble, somebody becomes enough of a nuisance, somebody takes notice and somebody takes proper action.

If somebody gets out on top of a building and says he will jump—

Q. We are not talking about emergencies.

A. Well, I am only giving you an illustration to make my point.

(29) If someone gets out on a building and says they are going to jump and they have been telling their family for weeks how depressed they are, when they get on top of the building somebody starts to notice.

So, the point is the police are brought in immediately.

Q. We are not talking about an emergency.

A. I'm talking about the fact that someone is doing something to bring him to someone's attention; that they need help, and the ordinary man in the street can tell that

somebody is walking with a limp. The ordinary man in the street can tell if someone's behavior is at odds with the usual behavior in that culture.

So, in that case somebody has some concern for someone's safety and someone's well-being. The law acts to protect the person.

Q. What is the need in that case to have a judicial hearing?

A. Since someone is taking someone else's needs as being something that needs to be attended to—

Q. Isn't the need for a juducial hearing to have an independent person find out whether the facts are as alleged?

A. If in that case you are talking about where there has not been a psychiatric evaluation—

Q. That's right.

A. The law says admit for the purpose of an evaulation since this person's behavior in some way is at odds with what the (30) usual is.

Q. Well, is there any reason for there not to be a procedure whereby the person to whose attention his symptoms came could apply for the potential patient's admission to the hospital without involving a judge?

A. Do you want to repeat that. I think I lost some of the posture there.

Q. Why not have a situation where, for example, the wife whose husband has been acting bizarre lately can apply to the mental hospital and say that my husband has been acting in such and such a way and I feel he neeeds some evaluation—would you support that kind of procedure?

A. And the patient is accepting or rejecting?

Q. Rejecting it.

A. Well, I understand that is what the law does allow for.

Q. The law does not allow that for adults. It allows that for children.

A. Yes.

Q. Is it your position that that ought to be allowed for adults as well?

A. I don't quite see what you're getting at.

Q. I'm trying to get you to answer a question.

MR. ROTH: Why don't you state the question, David.

BY MR. FERLEGER:

Q. Is it your position that the law ought to provide that (31) this hypothetical wife should be permitted to have her husband involuntarily admitted upon her application and description of his bizarre behavior to the psychiatrist at an institution?

A. No, because the psychiatrist then would do an evaluation before he would commit him.

With no evaluation before, then you have the law to allow for a judicial hearing.

Q. And if there would be an evaluation by the psychiatrist—suppose the law would provide that two psychiatrists should evaluate this involuntary husband, and if their evaluation indicated that he was mentally ill and could benefit from treatment, would it then be your position that he ought to be involuntarily committed to the institution?

A. Yes. There would be enough evidence on that basis to provide a substantive diagnosis and recommendation for hospitalization.

Q. All right.

So, based on that two-doctor recommendation, are you then supporting the law—

MR. ROTH: I object to this line of questioning because what you are trying to do with the doctor is trick him because you know of a case involving recommendations by two physicians was deemed inappropriate and unconstitutional; and Dr. Sugar is not familiar with all the Mental Health Laws of Pennsylvania. He has familiarized himself with the sections in (32) question, and I think it would be appropriate to address the sections in question and with regard to his opinion of those and the treatment of juveniles versus the treatment of adults and the procedure after safeguards afforded each. I do think it is inappropriate. I think it is misleading. To attempt to secure from Dr. Sugar an opinion, fine. He can give us his professional opinion, but with regard to things that he may feel should be acceptable which have been declared invalid, is really irrelevant to this lawsuit.

MR. FERLEGER: You know perfectly well, Barry, that it is perfectly relevant if Dr. Sugar is sincere, honest, professional opinion is that procedures ought to occur which, in fact, the laws and the courts have ruled cannot occur.

If his opinion is that certain procedures which are unconstitutional or medically proper—I think that is highly relevant to the lawsuit, and if as Dr. Sugar has stated his opinion, that doctors after doing an evaluation should have the power to involuntarily treat people, that is very relevant to the lawsuit.

This lawsuit involves equal protection as well as due process claims; the reasons for the difference in treatment of adults vis-a-vis children are also relevant.

MR. ROTH: And that should be the major focus with regard to the treatment and the procedures afforded juveniles versus afforded adults.

(33) MR. FERLEGER: You can't tell me what my question should be.

MR. ROTH: I know. But I am objecting just the same.

THE WITNESS: I would like to point out that I came here prepared to talk about juveniles and the nature of juveniles and their special needs rather than adults.

BY MR. FERLEGER:

Q. The nature and difference between juveniles and whom?

A. Adults which, I think, I explored earlier in some detail about this development and their function being incomplete.

Q. Dr. Sugar, did you come here to speak about—strike that.

MR. ROTH: Well, I object again and—

MR. FERLEGER: He can make any statement that he wants under examination by you. Right now it's cross-examination.

MR. ROTH: Fine.

There was a comment that you had made to him and he had replied to your comment and you seemed to have rapidly cut him off.

MR. FERLEGER: No. He was not replying to any comment of mine, and the record will show.

BY MR. FERLEGER:

Q. Dr. Sugar, you consider yourself an expert in adolescent psychiatry or child psychiatry as well and younger children, do you not?

(34) A. Both.

Q. You made a number of comments earlier with reference to adolescence; the fact that there are hormonal changes and growth changes, sexual changes that don't get completed until their twenties.

Now, isn't the picture a little bit different with regard to persons who were, for example, under 13, for example, not adolescents?

A. What picture?

Q. Their psychiatric status.

A. I don't know what you are asking.

Q. Well, all your comments about adolescents do not necessarily apply to younger children; isn't that correct?

A. Well, not all of them, but generally they do apply in that there is still growth. There is incomplete, physical and emotional development in younger children, and that they're in need of someone to care and be responsible for them.

Q. Now, Dr. Sugar, you commented that it is your estimate that about 10% of children need psychiatric help; is that your estimate?

A. I wasn't making an estimate. I was just using that as a figure for the purpose of my comments.

Q. What is your estimate of the number, the percentage of children who need psychiatric help?

A. I don't have an estimate of that. I don't have a figure (35) handy to give you. We can look it up in the literature, if you want.

Q. Do you have any estimate of the percentage of parents who need psychiatric help?

A. It's been stated about 10% of adults. It's been stated about 10% of children, but I couldn't give you that as a specific, accurate figure. I am just saying that is a round figure.

Q. Now, Dr. Sugar, one of the questions involved in this lawsuit is how much reliance should be placed upon the parents' evaluation or reporting of various behaviors of children.

My understanding is that it is your testimony that a substantial reliance should be placed upon the parents; is that correct?

A. On whomever they are living with. We assume for the purpose of this discussion that it is the parents.

Q. Okay.

Parents or guardians or whoever.

A. Yes.

You can also utilize data from other people that the youngsters are involved with in a substantial sort of way.

Q. Would it be your position then that commitment to an institution could be made on the application of other people besides parents, guardians of people in loco parentis?

A. Well, I think that covers it.

Anybody who is in loco parentis for that moment (36) can take action to protect the youngster.

Q. So that a child—while a child is in school, do you think he ought to be permitted to be committed by a school official without regard to the parents' wishes?

A. If the child is in a boarding school.

Q. I am talking about a regular public school.

A. I think I am not really saying that at all.

Q. You mean a boarding school?

A. Yes.

And he is in charge of loco parentis of someone else and they have responsibility to look after the child.

If the child suddenly is exhibiting bizarre behavior destructive in some way or other to himself or others, they have responsibility to exercise protection for that child.

Q. How about in the non-emergency situation? Do you think that the boarding school ought to be permitted to commit a child without the wishes of the parents?

A. I would assume that they would contact the parents. I would assume that they would do something procedurally proper to get an evaluation.

Q. I'm asking you what you feel psychiatrically.

A. Well, that's what I would feel would be the more psychiatric approach.

Q. That the parents should be contacted?

A. The boarding school should contact the parents. The (37) parents should seek appropriate evaluation and appropriate steps should be taken.

Q. It is your testimony, is it not, that you feel that parents or people in loco parentis ought to be substantially relied upon for the reporting and noting of various behaviors of the children?

A. Yes. They are the ones who have the most contact with the youngster.

He is living with them and spending most of his time with them. So, they're able to observe his behavior and changes.

Q. Now, with regard to situations in which there is disagreement between the potential patient and the parent, who is it that you think is in the position to figure out what the actual facts are? Is it the physician or psychiatrist?

A. I would think so. I would think that he should try to assess the situation from both sides and weigh the data and the observations of the youngster's mental functioning. That is what he is trained for.

Q. I might have misunderstood your testimony, but I understood you to have testified that many so-called juvenile delinquents, juveniles who commit behavior that the law considers criminal, that many of them also have emotional problems; is that right?

A. Yes.

(38) Q. Now, when a juvenile delinquent—that is a juvenile accused of some criminal act, and assuming the juvenile also has emotional problems, when a decision has to be made about what kind of rehabilitation has to be done for that child or whether, in fact, a juvenile actually did commit that behavior, who, in your opinion, should make that kind of decision?

A. I don't quite understand.

Q. Who?

A. If a juvenile has done something?

Q. When a juvenile is accused of a criminal act and that juvenile is accused in juvenile court of that criminal act, somebody has to decide whether or not that juvenile committed that act; is that right?

A. Yes.

Q. Now, the juvenile may have one story. His mother may have another story and the shopkeeper might have a third story; isn't that possible?

I didn't hear your answer.

A. I didn't answer.

Q. Well, can you answer?

A. I'm still listening to your question.

Q. My question at this point is it is possible, is it not, that the juvenile will have one story, his mother will have another story and the shopkeeper, for example, might have a third story?

(39) A. Yes, it's possible.

Q. Now, who, in your opinion, should decide which of those stories is true or what facts actually occurred?

A. I think that that is really a question that I couldn't give you an opinion on since you are saying it is a criminal case. He has been apprehended. Somebody has charged him with something. I don't think that is a medical case at that point.

Q. It is a case in which the facts have to be decided by a court; isn't that right?

A. Yes.

It is a court case at that point. It may be a medical case later.

In other words, if the assessment of what is going on leads someone to start thinking that this behavior is connected with something of an emotional disorder, then the Court would, I presume, would call on psychiatric consultants to do an evaluation.

Q. Now, Dr. Sugar, in a situation where a juvenile is accused by a parent of, let's say, acting in a hostile or retaliatory way toward a parent or juvenile and is accused of some bizarre behavior such as ripping up all the books or toys in a room or some other strange kind of behavior, isn't the first question for a psychiatrist whom this comes to the attention of, isn't the first question whether or not that behavior occurred and then if the doctor decides the behavior occurred, the question is (40) medically what is the diagnosis and the best course of action? Isn't that the process that you follow as a psychiatrist?

A. It varies according to the individual situation.

Q. In the case that I gave where a mother comes in and says that "My child has been doing all these strange and bizarre things," isn't one of the things you want to know immediately whether or not that is true?

A. Well, I would hope to get that data in the course of the evaluation. Whether I would get it in the first or ten questions is beside the point.

Q. You feel that is important information for your evaluation?

A. I would like to have the youngster's tale about what he thinks is going on.

Q. Do you understand that the purpose of this lawsuit is not to exclude psychiatrists from the picture altogether, but to have that factual evaluation done by a Court rather than a psychiatrist? Do you understand that that is the purpose of the lawsuit?

A. I really don't know what you are trying to ask me with that question.

Q. I am asking whether you understand that that is the purpose of the lawsuit.

A. To do what?

Q. To have a Court—

(41) A. Assess—

Q. —make that factual determination.

A. Of whether the kid did do or didn't do something?

Q. That is correct.

A. In a non-criminal case?

Q. That's correct.

A. And thereby seek to do what?

Q. I'm asking you if you understand that the purpose of this lawsuit is not to exclude psychiatrists?

A. "Altogether," you said.

It sounds like you are saying you want to exclude psychiatrists.

Q. Well, that is what I am trying to explain to you and clarify because, evidently, you have a misunderstanding from the defendants' counsel.

A. I didn't say that. It's my understanding—my understanding is—by the way, you are suggesting that you are delaying getting help for the youngster when he needs help. That is my point.

I was not saying what you were just quoting me as saying at all.

Q. Do you understand that the purpose of this lawsuit is to have those factual questions decided by a Court?

If that is not your understanding of the lawsuit, just answer no.

(42) A. I don't understand what you are saying really since my understanding of it was having to do with the judicial process preceding psychiatric attention.

Q. Your understanding is that this lawsuit involves a delay in obtaining psychiatric care for juveniles?

A. Yes.

Q. Now, can you explain why you feel that the emergency commitment provisions of the Pennsylvania Mental Health Act are not sufficient to get around the problem of delay in obtaining needed treatment for juveniles?

A. Well, sometimes they may not be of a level that makes them seem of an emergency basis to the casual onlooker, whether it is the family or anyone else.

Q. Isn't that also true of adults?

A. Somewhat, except that adults have more means at their disposal to do something for themselves, whereas

if a youngster is assessed as having some problems and the family takes him to a psychiatrist and the psychiatrist says this kid needs to be in a hospital—

Q. Except we are talking about adults that may be severely disturbed.

A. I really don't understand what you are getting at.

I am lost again.

Q. Dr. Sugar, —

A. I seem to have trouble following what you just said.

(43) Q. Dr. Sugar, for adults who may need or may not need psychiatric help, adults who exhibit some strange or bizarre behavior, isn't it true that in non-emergency situations delay may also be not advantageous to that adult's mental condition?

A. Yes.

Q. And it is true for children as well that delay can be a problem?

A. Yes.

Q. Dr. Sugar, are there situations where parents can be antagonistic or disruptive to what may be beneficial for their children's mental health?

A. Yes.

Q. And it's true, is it not, that there are situations where parents have psychotic children by obstructing or resisting attempts to help their children?

A. Yes.

Q. Am I correct?

A. Yes.

Q. If parents behave in that manner, you are not suggesting that they ought to be the ones who make the application to mental institutions, are you?

A. Well, usually, unfortunately they are the ones—they try to disguise the situation, but if the child goes to school or is in some way—at some times he is outside the home, it may come to someone else's attention, in which case, some (44) representative of society like the law may suggest something be done about it, or if the kid is picked up shoplifting 10 times and the parents don't see anything the matter with it, somebody may say this youngster needs to be put into a youth center by the law and then evaluated psychiatrically because the parents aren't doing something. They are not assessing the situation properly.

Q. Dr. Sugar, you have testified about a number of children who have expressed to you the anxiety and relief that children often feel about being institutionalized. For that sort of child, is it your opinion that he or she ought to be allowed to commit himself with the doctor's approval?

A. In that case the doctor takes the position of loco parentis.

Q. All right.

So, if a child wants to be given professional psychiatric assistance and if psychiatrists or a hospital believes that that child is in need of assistance, you would approve procedures whereby the child could then get assistance?

A. That's the law in terms of loco parentis. Someone would do something on an emergency basis.

Q. That would even be if the parent was one of the parents who felt that psychiatric care wasn't necessary?

A. If it was an emergency, yes.

Q. How about if it wasn't an emergency?

(45) A. Then you have a question of the law, and someone has to be responsible to take the child away from the parents to do something, just like in child abuse cases.

Q. In your expert opinion in a situation where the parents don't want treatment, but enough psychiatrists and the child both feel that treatment is needed, you feel that the law and the Court should be involved at that point?

A. For the protection of the child, yes.

Q. Thank you.

Now, it's true, isn't it, that very often parents may misinterpret behaviors of their children and feel that certain actions or what doctors would call symptoms, symptomatic behavior, are more serious than they actually are; isn't that correct?

A. Yes.

Q. There may be situations where, for example, a mother might feel that a child is attacking her even though that is not true?

A. Yes, that could be.

Q. And in a situation especially where the parents might be having some problems among themselves, that kind of information from a mother to a psychiatrist would not be very reliable; isn't that correct?

A. It would have to be weighed against the total situation, sure. The mother might be psychotic herself.

(46) Q. And it's true, isn't it, that in situations where the parents may be having problems, children may be subject to extreme deprivation of their emotional and their physical needs; isn't that right?

A. Yes.

Q. And in that kind of situation, would it be your opinion that the law ought to permit the parents to initiate institutionalization of children?

A. If the child needs institutionalization, then the parents aren't capable of making an accurate assessment. Someone needs to be able to step in to do something about it.

Q. And to make that assessment?

A. And to get the assessment done, yes. Somebody needs to evaluate that.

Q. Now, the difference in our opinions evidently, Doctor, is that you feel that solely doctors should be involved in making that assessment and the plaintiffs feel that the facts ought to be determined by the Court, and that the doctors ought to determine the psychiatric implications of those facts.

Now, in that situation where the parents might be in turmoil or conflict, where the child might have behaviors that are reported by the parent to the psychiatrist, do you see any reason in a non-emergency situation which Courts and psychiatrists couldn't work together to determine what is best for the child?

(47) A. I have no objection to the Court and psychiatrists working harmoniously together.

Q. Because in that kind of situation it is true, isn't it, that it may be impossible to get the parental cooperation that is needed for the best interest of the child?

A. It may be, in which case it may be useful to have the child put into another home or an institution where they can be evaluated and observed properly.

Q. And should that decision be made by a psychiatrist or a Court?

A. Well, that decision would initially have to be made by the law since someone has to bring it to the legal attention; the police or the Courts would have to do something to prevent the child suffering further. So, the first step would be someone noticing the behavior being not ordinary anymore and someone needs to then put the child in a safe place where they can then be evaluated.

Q. Doctor, would you, please, give me your opinion about the extent of mental illness among parents of mentally disturbed children?

A. I don't have a figure on it.

Q. Well, in your experience—

A. I don't have a figure.

Q. I am not asking for a figure. I am asking for your estimate or evaluation.

(48) A. Well, you are asking me for a figure. I can only say it does happen. I don't have figures to supply you with at this moment.

Q. Is this frequently or infrequently?

A. It depends on the nature of the situation.

If the youngster is severely ill, is a psychotic kind of youngster, there is a tendency perhaps to find a somewhat higher percentage of serious illness in the family.

Q. It would be a tendency then for psychotic children to come out of a family situation in which one or more of the other family members might also have serious mental problems?

A. There would be a tendency, yes.

It's not a genetic kind of factor at this point as far as we know, although some people feel it is, but it is not generally accepted.

Q. Isn't it true that it often happens that the behavior of adolescents which might be quite typical and normal for adolescents might frighten a family unduly?

A. No. I wouldn't think so, no.

Q. Would it frighten the family into being sort of overly concerned about the behavior of the adolescent?

A. I wouldn't think so unless there is something bizarre about the behavior—unless there is something bizarre about the parent.

Q. Well, if the behavior was so bizarre in the parent's eyes, (49) isn't it true very often that might be simply normal adolescent behavior?

A. It might be, depending on the parents' set of values and vantage points, sure.

Q. Well, if that bizarre behavior occurs, isn't it true that the parent—that the child might appear frequently more disturbed than he is and may frighten his family?

A. Potentially in that case where there is that kind of distortion in the parents.

Q. Potentially—or isn't that absolutely true?

A. I don't feel we can make that kind of comment at this point.

Q. When you wrote your article in the American Journal of Psychotherapy, "Normal Adolescent's Morning," didn't you make that very statement?

A. Do you want to quote it to me? I don't recall it.

Q. You stated that "When bizarre behavior occurs during a distortion phase the adolescent may appear to be more disturbed than he is and might frighten his family."

A. Yes.

What I was referring to there was a brief episode of something strange or unusual. The youngster has a reaction to something and he has a strange kind of response, and the parent may feel frightened about the thing temporarily.

Q. And during that temporary, frightened phase, isn't it (50) correct that the parents might decide incorrectly that the child needs psychiatric help?

A. They might; but what I was referring to in that article was a temporary phase, which means, that the usual course of it is that the parent sees a fluctuation in this.

If you recall the rest of the point I was making there it had to do with this being a fluctuating situation.

Q. Let's read it.

A. Therefore, it would be something that would become altered, and the parents might not continue with their frightened response.

Q. But the other thing that can happen—isn't it that the parents might withdraw and not even realize that the child needs help?

A. Yes, they might withdraw.

Q. And then—

A. They might overreact and say "Let's rush to the psychiatrist."

Q. If they withdraw, in that case the child would be deprived possibly of needed psychiatric help?

A. No. If that is put in the context in which I was writing, just on the basis of that kind of thing in a normal process, this would get taken care of by itself through the usual developmental processes going on. Therefore, they would not be depriving the youngster of what they are ordinarily doing for him.

Q. But it is possible, isn't it, that, for example, that (51) the child may speak to a physician and the physician may side with the parents, and in that case, the child may be deprived of help?

A. Sure. It's possible. He might not recognize the situation for what it really is, sure. Errors can be made.

Q. You stated in your article, didn't you, about the parents' bizarre behavior and that the child—that they may then withdraw or react antagonistically and miss the adolescent's real need of help through supporting controls.

If the physician identifies himself with the parents he may also lose sight of the basis of the adolescent's behavior; is that right?

A. Yes.

Q. So, there are situations then where the doctors wrongly identify them with the parents' side of the picture?

A. They identify with one or the other, and this may lead to difficulties, yes. This may happen since everyone is subject to error. That is my point.

Q. In a situation where parents are having some marital problems and—

A. Excuse me. Let me just go back to the point that I was making about withdrawing. I was referring to that in terms of a technical sense of not giving the youngster control and support. They just say something very negative or sort of say "You are on your own" or boot him out, and their response to their (52) behavior instead of realizing what it means—withdrawal means—this is not a withdrawal of monetary support. They just don't understand. They don't control and let him understand that they are still there to look after him.

Q. But there are situations where the withdrawal may result in a withdrawal of physical needs as well?

A. Yes.

Sometimes parents overreact to that degree also.

Q. You stated, as a matter of fact, in your article "Divorce and Children" in the Southern Medical Journal that with reference to divorce "The subsequent guilt or change in their matrimonial fortunes might leave the child unattended even to minimal, emotional or physical needs."

A. Yes.

Q. Further, "Confusion results from this oscillation between overindulgence and deprivation."

A. Yes.

Q. So, especially in the course or other unstable situation we come across cases where the parents can't really be depended upon to look after the best interests of their children.

A. Right, because they are in a stressed state themselves for that period of time, yes.

Q. And you might have situations, might you not, where the children's symptomatic behavior is a result, not simply of the child's own internal problems, but a result of the turmoil in (53) the family?

A. Yes. They have a reactive response to the situation.

Q. In fact, the story you told about that boy who got into trouble just, I think you said in the past week or two, his situation was one in which you testified that his father and his mother wouldn't step in to help him get hospitalized.

A. Well, they accepted the hospitalization. They wanted him to be hospitalized. They didn't do the extra little step which would have safeguarded him.

Q. Which would have kept him from getting arrested?

A. Right.

Q. It's true, isn't it, that in this divorce or unstable situation that the parents—well, let me quote from your article and you can tell me if you still agree with it:

> "Parents may interpret the child's behavior as retaliation due to their own feelings of guilt about having broken up the child's 'happy?' home, but the child usually is not deliberately revengeful and his

responses need to be viewed in the context of feeling hurt, frightened and angry about the loss and his need to let the parents know about this."

Do you still agree with that statement?

A. Yes.

Q. So that there may be situations where psychiatrists or institutions are confronted by parents who might simply give (54) their view of the behavior of the child without explaining the possibly, embarrassing marital situation and where psychiatrists might, in an unwarranted way, side with the parent before they can find out the actual picture?

A. Well, no.

I would have to qualify that statement in terms of a psychiatrist's job. It is to assess a child's functioning and what is going on with him emotionally, not just on the basis of the parent's complaints, but on the basis of evaluating the child and getting the child's story about what he feels and what has been going on and assessing his mental status and then coming to some diagnostic appraisal.

Q. And that assessment also involves assessment of the facts?

A. It involves an assessment of the facts; involves an assessment of what the parents are really saying as well as what the child is really saying. Hopefully, this gets to a more accurate appraisal diagnostically.

Q. Can you tell me what, in your opinion, or by your training gives you the extraordinary qualifications to decide what facts are true as opposed to the mental status?

A. I am afraid I don't understand what you just said.

Q. Well, in evaluating—

A. Since nobody claimed extraordinary kinds of powers which you are imputing—

Q. Well, have you ever participated, Dr. Sugar, in the (55) commitment of an adult?

A. Yes.

Q. Have you ever been in court during a judicial procedure for the commitment of an adult?

A. Yes.

Q. Have you ever testified in that kind of proceeding?

A. Yes.

Q. Now, at that proceeding you heard testimony, didn't you, from possibly conflicting sources about what kinds of behavior the person engaged in; isn't that right?

A. (No response.)

Q. You have to say "Yes" or "No" so the court reporter can hear you.

A. Yes.

Q. And in your psychiatric practice you also hear conflicting versions of the facts; isn't that right?

A. Right.

Q. Now, in that judicial proceeding for the commitment of an adult, it is true, isn't it, that it is the Court that decides on the conflicting facts?

A. Yes. That is what the commitment is about and is based on the evidence.

Q. It is based on the evidence?

A. Of the diagnostic appraisal.

Q. And the conflicting facts?

(56) A. And the complaints.

Q. Now, can you explain the reason that the commitment shouldn't also be about the same thing for juveniles? Why shouldn't there be a situation where the con-

flicting facts are given to the Court and the diagnostic appraisal of the psychiatrist is given to the Court and then the Court decides what needs to be done?

A. Why shouldn't there be commitment?

MR. ROTH: Objection on the basis—are you dealing with the same thing that we have been discussing before in terms of a judicial proceeding prior to commitment?

MR. FERLEGER: The question speaks for itself.

MR. ROTH: In order for Dr. Sugar to be perfectly clear on exactly what he is being asked, one of the things you are seeking is a judicial hearing prior to commitment. We don't want to mislead the doctor in not thinking that that is not exactly what you are asking, if that is what you are asking of him.

MR. FERLEGER: I asked the question and the doctor can answer the question.

MR. ROTH: But the question is not clear in my mind in the sense of your saying that evidence should be presented to the Court prior to commitment in order for the Court to make a decision; is that correct?

MR. FERLEGER: You spoke, Mr. Roth, before the (57) doctor had a chance to explain whether the question was clear in his mind.

THE WITNESS: I said it wasn't when I asked to have it repeated.

MR. FERLEGER: (To the reporter) Would you read the question back?

(Whereupon the pending question was read back by the court reporter.)

BY MR. FERLEGER:

Q. Did you hear the court reporter read back the question?

A. Yes.

I still don't understand what your point is.

Q. What is the reason for the juvenile who can't have the same procedure that you just described having been a participant in whereby the conflicting evidence is presented to the Court and the medical diagnosis is presented to the Court and then, as you have testified, the Court makes the decision about what needs to be done in a non-emergency situation?

A. Well, with the adult there is usually no one in loco parentis, except the Courts, and the law, and this is supposedly there to protect and safeguard the individual as well as society.

With the child you have the safeguard by parents, and since both parents function fairly suitably in that role, they are not going to want to incarcerate a child unless there is some specific need for it based on somebody's evaluating it (58) and having it then taken care of professionally; but if the procedure that you are suggesting be done, then I would see perhaps a nice increase statistically. I don't mean nice in terms of benefit. There would be quite a considerable increase, I would think, in terms of more crimes and more violence and more suicides and more other violent acts. There would be longer waiting lists to see psychiatrists, and it would be quite deleterious to the youngsters.

Q. Because you mean it is easier to get youngsters into treatment under a non-judicial procedure?

A. I am pointing out that there would be less delay in getting them help since the parents are assessing the child's needs rather than having someone evaluate and then somebody start some treatment procedures.

Q. When you talk about longer waiting lists and more crimes and all that sort of thing, under a judicial procedure, are you saying that judges are less likely—that the judges are likely to commit a smaller percentage of people than doctors would commit?

A. I am not talking about the percentages of commitments. I am talking about the delay in doing something needed for the child.

Q. But you have that delay, don't you, with adults as well and adults are capable of committing as serious crimes and disturbing behavior as juveniles, correct?

(59) A. Usually, in that case if a child—if the adult is in some way causing difficulties he is usually under the protection of the law.

Q. What do you mean "protection of the law"?

A. Well, he is usually safeguarded by the police, isn't he, or some other situation, or he is under a peace bond by the family to keep him in some kind of state where he is looked at.

Q. It is your information that there is no such procedures available for juveniles?

A. My point is not that there is no such procedure. My point is that you are impeding the pursuit of treatment and the delay would lead to more difficulties if the institutionalization isn't done when it is needed.

Q. But your testimony is for adults the way we get around that problem is by having peace bonds and other protections of the law?

A. You can put an adult in jail if you need to. Where would you put a child?

Q. In a juvenile institution.

A. There is a question of how suitable it is for the job.

Q. Isn't there a question as to the psychiatric institution for children?

A. Yes. It is a different sort of evaluation and a different sort of structure.

Q. Isn't there a question of how suitable jails are for (60) mentally ill adults?

A. Yes.

Q. So then, what are the alternatives for the adults? There is a delay for children and there is a delay for adults, isn't there, and they are both not very good for a psychotic's mental health?

A. Part of the delay with the adults is that society, I gather, is acting in loco parentis. Someone is taking the responsibility to do something to look after this person's interest whereas the child, the parents are looking after the incompletely, undeveloped person and his needs and they are looking after him.

Q. But you testified earlier for the child—it can be the police or the school or some other person besides the parents.

A. Yes, who first notices the behavior and brings it to someone's attention.

Q. Who looks after the interest of the child?

A. In loco parentis, if it isn't an emergency situation—

Q. Well, in the non-emergency situation—I still don't understand why we don't have the same problems for adults. We have the delay. We have the jails that you

testified are not very good for mentally ill adult problems.

Why should we have judicial procedures before an adult commitment?

MR. ROTH: I object on the basis that the question now is becoming argumentative and the doctor has responded (61) several times to it in connection with the development of the adolescent, et cetera, et cetera.

I think he responded at least three or four times, which the record will reveal.

BY MR. FERLEGER:

Q. In terms of the adult, do you feel psychiatrically that there is a need for a prior, judicial hearing before a commitment?

A. I presume I was here to discuss adolescents.

Q. And also differences between adolescents and children.

A. And their needs which, I think, I have answered.

Q. Can you answer my question? If you feel unable to answer, you can state that, but can you explain to me whether or not psychiatrically there is a need for judicial hearings before commitment of adults?

MR. ROTH: Is that before the voluntary admission by an adult of himself or before an involuntary commitment?

MR. FERLEGER: For an involuntary commitment.

THE WITNESS: If the person objects to being in there, whether he is delusional or not, if he calls counsel to look after that interest of his, then for

the sake of the law and the patient's understanding that he is in need of being there, not just because of psychiatric testimony, then this supports his need to be in the institution.

BY MR. FERLEGER:

Q. Dr. Sugar, isn't it true that a judicial proceeding can (62) also be traumatic for a juvenile delinquent who is in Juvenile Court?

A. Yes.

Q. And it is true that a proceeding which is a judicial proceeding can be traumatic for an adult as well?

A. Yes.

Q. An adult mentally ill or not mentally ill?

A. Yes.

Q. Lots of people get anxious and upset before appearing in court even for a traffic violation.

A. Yes.

Q. Now, you testified that you are familiar with the Gault Decision which requires hearings for juveniles in Juvenile Court when that procedure is for their rehabilitation.

Can you explain why the trauma of that hearing for that juvenile delinquent isn't enough to make it, in your psychiatric opinion, inadvisable to have a hearing?

A. At that point we have to establish if there is a psychiatric condition which needs immediate attention.

Q. Assuming we have one of those juveniles who is a juvenile delinquent or at least an accused one who has, as you testified many of them do, an emotional problem—

A. Yes.

Q. —would you, in that case, if a judge called you up, would you advise the judge not to have a hearing because it (63) might be too traumatic for the kid?

A. Not without my evaluating. I couldn't make that statement.

Q. If you had evaluated?

A. If I had evaluated him and I had come to that conclusion, yes, I would tell the judge what I thought, and if that was my opinion, I would render it.

Q. So you can conceive of a situation where it would be your medical opinion that the best interest of a possibly, emotional, disturbed juvenile delinquent where his best interests would not be served by having a hearing; is that right?

A. Right.

Q. Now, Dr. Sugar, you testified that commitment is sometimes appropriate for a number of classes of juveniles, and one of the situations you described in these words was "Some people don't fit into the family scheme."

Now, can you explain exactly what you mean by that?

A. Yes.

I was referring to someone who is psychotic and bizarre in their behavior and having delusions, persecutions, and they feel that everybody in the family is poisoning them or out to hurt them or people—or people in the family trying to accommodate to that. They have further accusations and threats made against them, and they are under constant strain because they feel the person is going to follow through on some of the threats they have made and in response to what they feel (64) are all sorts of perfidious deeds.

Q. For juveniles who have less serious problems, isn't it true that there may be situations where foster care or temporary care with a relative or some group, home-type situation where some treatment, alternative or living alternative—or some institutionalization might be appropriate?

A. Yes, that is sort of a form of institutionalization.

You are removing them away from the home which is sometimes treatment in and of itself. You are putting them in a foster care situation which sometimes is very useful treatment.

Q. In your opinion, should that decision be made by the Court or by a psychiatrist or by both?

A. I think it should be a psychiatrist's opinion in terms of the youngster's emotional needs and in terms of what this might potentially benefit him with by placing him in that kind of an institutional setting.

Q. Now, when a parent neglects a child or doesn't give the child enough to eat or, you know, someway is in a gross way not responsive to the needs of the child, and the child needs that kind of alternative placement, is it your opinion that that decision should be made by a Court or by a psychiatrist or by both?

A. Well, in that kind of situation, we are not talking necessarily of a psychiatric condition. We are talking about ordinary needs not being met, and the law or the family doctor (65) should be the responsible one for that.

Q. The law or—

A. We are not talking about a psychiatric condition there.

Q. That's right.

Who should make the decision?

A. Well, it is a legal question ultimately. It is obviously a legal question.

The doctor can initiate this, which is, for instance, what happens with child abuse cases.

Q. So your standard seems to be then when it is a medical or psychiatric question that the Courts shouldn't be involved?

A. No.

Q. But when it is a legal problem—

A. If it is a legal problem the Court should be involved to implement what is necessary for the law to implement and what is needed for the youngster just as I said in the child abuse cases. The pediatricians are the first ones to make the diagnosis and to bring attention to this. They are the ones that call the law. The law follows through on the diagnosis and places the child elsewhere for its own protection.

I am really not saying what you just intimated. I was saying that they can work harmoniously together, just as I mentioned.

Q. Now, in the case of a child who is, let's say, five years old, six years old, seven years old, do you feel that a child of (66) that age is mature enough to decide whether or not he or she wants to be institutionalized?

A. No.

Q. Now, in a situation where a parent might feel and perhaps a psychiatrist might feel that institutionalization is appropriate do you feel that the decision of the parent and the psychiatrists ought to be enough to effect institutionalization without the Court's interference?

A. Yes.

Q. You don't feel that there is any necessity for someone to be appointed to represent the interest of the child separate from the parents?

A. No.

What you are suggesting, if that is done, is that there is no need for the medical profession; that the medical profession's diagnosis and recommendations are not of any value.

Q. Well, it's true, isn't it, that just as when we have a hearing in this case, we will have experts, medical experts on both sides say that if someone who is interested in representing the child's interest separate from the parent's chosen psychiatrists, that we could have medical opinions on the other side of the point?

A. You may.

Q. And when there is that conflicting medical opinion, who do you think should make the decision?

(67) A. Well, I feel in many cases the conflicting medical opinion is either resolved by the parents, if it is a legal case, and if it is the responsibility of the judge, then the judge takes that into consideration.

Q. Well, this whole suit is about whether it should be a legal case.

If we have a situation where we have conflicting medical opinions about whether a five-year old ought to be institutionalized, is it your opinion that the parents ought to make that choice or that a Court ought to make that choice?

A. Why would it be a court case in the first place at age five?

Q. That is what the lawsuit is all about.

The plaintiffs' position is that the parents shouldn't be allowed to make that decision without it being a court case.

The defendants' opinion is that it should be.

You are the expert, and I want to know what your opinion is.

A. My opinion has been—

Q. That it should not be a court case; is that right?

A. Unless there is reason for it to be a court case.

Like, a criminal action or something that brings it—

Q. Without a criminal action when the child—

(68) A. I don't see the need for a court case.

Q. You think that the parents should be the ones to make that decision?

A. The parents are the ones who bring the complaint. The doctors are the ones you bring the child to.

Whether he is five or 15, the doctor is the one that makes the assessment.

Q. And the parents should be the ones to make the decision about institutionalization?

A. The doctor makes the decision. The parents follow through.

Q. If there is conflicting—

A. Then they can get a third person.

Q. And if there are ten opinions—

A. Then it is their ultimate choice, unless there is a legal condition such as a criminal act.

Q. If it is the parents' ultimate choice, what do we do in a situation in which you have testified to, where the parents have their own problems and are not in a position to make that choice?

A. Well, fortunately, those don't happen that frequently.

Q. When they do happen, we could have a situation where the parents are making a choice and it is not in the best interest of the child, couldn't we?

A. Well, if the child is in an institution, we presume that the people there are trained physicians; trained to do the proper (69) job, and that the child, if he doesn't belong there, they will do something appropriate about that. Otherwise, we get in a position ultimately according to what you are suggesting of having it like in Russia where the judges decide for political reasons that someone has a psychiatric condition.

Q. I don't understand why my five-year old suddenly is a political prisoner.

A. I am just extending your argument; that the doctors and the parents don't have the responsibility, and the State has the ultimate choice about matters that ordinarily are parental responsibilities.

Q. You did testify on direct examination, Doctor, that the dumping into mental institutions which Chief Justice Burger is concerned about has happened and the parents do abuse children.

A. It does happen, unfortunately, yes.

Q. And very often that happens with the cooperation of the psychiatrist; isn't that right?

A. It may be happening, but I think that the frequency of this happening—I would think that has been overstated by your comment.

Q. By what?

A. It has been overstated by your comments.

Q. Now, I would like you to explain, Doctor, your comment earlier when you testified, and I think these are your words, "That the point of having a hearing is mixed up with (70) sentimentality."

A. Well, yes.

You are saying that a five-year old should have the right to say I want a hearing.

Q. No, I am not saying that.

A. That was the case you were just talking about hypothetically, about the five-year old.

Q. I asked you whether or not a child had the maturity—

A. No, he doesn't.

Q. —to ask for a hearing.

A. No.

Q. I did not state my opinion on that.

Can you please explain your comment that the point of having a hearing for children 18 and under—that is the age range we are talking about which is mixed up with sentimentality.

A. You are assuming that an 18-year old, in spite of the points of developmental situations being incomplete, has the capacity to completely understand his condition when he is emotionally ill, needing hospitalization or when he is retarded intellectually and has an I.Q. of 50, and you are assuming, according to that, that the parents have no intelligence and no adult development, although apparently, they must have to arrive at that point in life.

Q. That is your definition of sentimentality to you?

A. I am not giving you my definition. I am pointing out that (71) there is an erroneous assumption that doesn't jibe with the facts; that the child's development, according to what is being proposed is complete. We know it is not. This also indicates that there is a question about the parents' abilities and responsibilities which is always deficient, which it is not.

Q. Well, can you answer my question now? You said the point of having a hearing is mixed up with sentimentality. Can you explain?

A. Yes. I am saying that everybody, according to this notion, is being put into a procrustean bed rather than a bed used for their development, their state of needs and the diagnosis.

The idea of everyone having a judicial hearing—it might be very nice, but it is really, I think, unnecessary in the vast majority of the situations.

Q. Well, that is also true, isn't it, for the various capabilities and intellectual and emotional levels of adults

as well? Don't we have the same procrustean bed where adults might be mere psychotic or might have absolutely no insight into their condition where all these adults are being given by the law? Don't we have the same psychiatric problem there?

A. I don't understand what you are saying.

What you correlate—since I said the parents take the responsibility; since their incomplete development is still their responsibility—

Q. But the law does not allow the parents of a 20 or 30-year (72) old child to take the responsibility when that 20 or 30-year old child is not able to take care of himself or herself?

A. I am afraid I don't know what you are asking.

Q. When you have a situation where a 25-year old woman is behaving in a bizarre way, let's assume she is living at home with her parents; where this adult woman is acting in a way which may be detrimental to her; where she may have absolutely no insight into what a psychiatrist would call her need for treatment, do you feel that her parents, acting in loco parentis ought to be allowed to decide on commitment?

A. Yes. That is just like for any adult. You have loco parentis in lieu of society at-large. Someone takes the responsibility. Someone like the policeman on the corner takes the responsibility.

You see someone doing something bizarre. He has his duty to perform of taking that person off the street for their protection and for society's protection.

Q. So those parents of the 20 or 30-year old, you feel they ought to be in the representation of society and it is your duty to be able to institutionalize their child?

A. In the usual procedure of having someone evaluate and assess what is going on, which is what is done—

Q. With or without a Court making the decision?

A. If the person agrees to it, then there wouldn't be a need.

Q. If the person has no insight at all?

(73) A. If the person has no insight and has a delusion that they're being persecuted and they want to have a lawyer come in and the lawyer says "You don't have a persecution complex; you are not psychotic and I will defend you in court—"

Q. Suppose there is no delusion of persecution. Suppose that the parents feel the child needs psychiatric help.

A. Yes.

Q. Suppose they invite a psychiatrist to come over for tea and the psychiatrist makes an evaluation and agrees, do you feel that the Court should be involved or should that psychiatrist's evaluation be sufficient?

A. The psychiatrist's evaluation should be sufficient.

Q. Dr. Sugar, how many articles which you have written have been published?

A. Approximately 35.

Q. How many of those articles deal with children?

A. I don't know.

Q. Do you have a list of your articles with you?

A. No.

Q. Do any of those articles deal with the law and psychiatry?

A. No.

Q. Have you had occasion to study questions involved in forensic psychiatry?

A. Not specifically in great depth. I have studied some.

Q. Just to clarify one further thing: When you stated earlier (74) "Due process is available in due time," you were not purporting to give us your legal opinion about what due process is, were you?

A. I was quoting what I heard here in terms of the law, allowing a hearing to be held in a certain number of days after institutionalization if the person chose to institute themselves.

Q. Now, suppose we have that hearing which is held after institutionalization and suppose the Court at that time finds that institutionalization is not proper and was not necessary; isn't it correct that that uninstituted institutionalization could have a bad or detrimental, psychological effect on a child?

A. Yes, it could have an upsetting effect.

Q. Now, Dr. Sugar, there is a law pending in the Pennsylvania Legislature which would change the age at which children could voluntarily admit themselves from 18 to 14. It would thus allow children between 14 and 18 to go in and out of mental hospitals of their own volition, and it would require parents to go to court prior to any commitment for 14, 15, 16, 17 or 18-year olds.

Based on your testimony here today, I would understand that you would be opposed to that kind of statute; is that right?

A. I don't understand what you are saying about the parents going to court.

Q. The law would require that only children under 14—the parents—strike that.

(75) For children 14 and over, for any kind of involuntary commitment, there would have to be a court procedure.

From your testimony about the problems of adolescence, I would understand that you would be opposed to that kind of statute?

MR. ROTH: It is not a law.

THE WITNESS: It is a current proposal?

MR. ROTH: It is a current proposal.

THE WITNESS: Well, I would like to see the law in its details before I could answer that appropriately.

BY MR. FERLEGER:

Q. Well, based on what I said—

A. Based on what you said, I would think that if a youngster says to a professional "I am upset, disturbed," et cetera, "I want to be hospitalized," and he presents himself at a psychiatric institution, he would not be admitted until he has been assessed.

Q. I understand that.

A. So then if he had been admitted and does need help, I would assume that they could keep him there since he wants to be admitted and he has a condition that needs attention medically, and the parents could be contacted then. Hopefully, they would agree with this.

Q. Now, where the child does not want to be institutionalized under this proposal that we are discussing, the parents would have to go to court for children 14, 15, 16, 17 and 18.

(76) Now, I understand that you would oppose such a procedure; is that right?

A. That's the thing that we are discussing here.

Q. Right.

A. Yes.

Q. Dr. Sugar, you testified earlier that you are being paid for your testimony here today. How much are you being paid?

A. $60 per hour.

Q. Does that include any preparation time?

A. Yes.

Q. How many hours have you spent in preparation?

A. I have not totaled it yet.

Q. Approximately?

A. Approximately two or three hours.

Q. Dr. Sugar, you testified that institutionalization can sometimes provide a comfort to the child, although the child may say he hates it. Are you familiar with any mental institutions in which a feeling of hatred or discomfort at the conditions there would be appropriate?

A. Yes. There have been a number of those described wherein some of the conditions were lax and there was some difficulty in maintaining some of the things required for the patient.

Q. So, if a child objected to being in an institution like that, there would be cases in which you would agree that the child's objection is correct?

(77) A. Yes; that he should be transferred to another suitable place.

Q. Now, Dr. Sugar, I have been told numerous times by psychiatrists that it is very difficult and sometimes impossible to treat patients who don't wish to be treated; that therapeutic results can be substantially improved through the use of—they can be substantially improved when the patient is voluntary and agreeable rather than involuntary and disagreeable; is that correct?

A. That holds for out-patient care, but for the in-patient, it is a different situation because they can be tak-

ing medication, which the staff can see to it that they get, whereas on an out-patient basis, there isn't that kind of control, and if there isn't cooperation from the patient, then the therapeutic effect may come to less than optimum.

Q. Isn't it correct that the medication which in-patients get helps get the patient to the point where other forms of treatment, you know, towards a possible cure or alleviation can begin? Isn't it true that the drugs are not, you know, any sort of cure—

A. Well, they have helped substantially, and many patients when admitted to the hospital are given doses of tranquillizers and they might get shock treatments, and in spite of the treatment—he might get over a great psychotic depression and get over it quite well despite their objection. They do get benefits and, many patients do get [illegible] of tranquillizers on a graduated (78) basis so they may leave the hospital. They are functioning better at that time. They know the severity of their illness and they can go back into society.

Q. Take the situation where a patient objects to the shock treatments which you have just mentioned.

A. Yes.

Q. Do you believe it should be the doctor's decision as to whether or not—

A. Yes.

Q. And not the Court—

A. That's right.

Q. How about procedures of an amygdalotomy?

A. That's your term.

Q. Or a cinculotomy?

Should those procedures be done based on a decision by a doctor or by a Court?

A. I think we are getting into the surgical field, aren't we?

I would suggest that as of the present time those procedures are still not quite far enough down the road. They are still experimental.

Q. Shock treatment you feel is a proven efficacy.

A. Yes.

It is the same question you are asking me whether the Court should approve on a million units of penicillin to be given—

(79) Q. What?

A. You are asking me the same kind of question if the Court—if a luetic should be given one million units of penicillin.

Q. That was the comment with reference to shock treatment?

A. Yes.

Q. It is your position then that whether a patient is voluntary or involuntary and an in-patient that that distinction of voluntary versus involuntary doesn't matter in terms of the kind of treatment that can be done?

A. It is preferable if he is cooperative because then you have a cooperative part of the patient to deal with, and it is easier to get on with the work, but there is resistance that has to be dealt with in terms of the opposition to it, and then it has to be dealt with. That's part of the problem also.

Q. Is it part of the treatment for an involuntary—

A. To cooperate?

Q. To be incarcerated?

A. To want to cooperate in terms of his own treatment.

Q. And that would mean to cease objecting to being institutionalized?

A. Not necessarily to cease objecting. He may continue to object, but as long as he cooperates in his own treatment, in spite of the objections, under the circumstances, just like patients may gripe about going to see the psychiatrist in his office, but they still come and they still talk about their (80) conflicts. They still gripe.

Q. In that situation the patient has a choice not to come.

A. Yes; because his functioning is such that he can get along without being institutionalized.

Q. You testified that the people with emotional problems may have trouble deciding or may have conflicts about whether or not to institutionalize themselves; is that correct?

A. Yes.

Q. It is true for adolescents as well as for adults, isn't it?

A. Yes.

Q. Both adolescents and adults—for example, your evaluation of them may make the incorrect choice as to what is medically appropriate; isn't that correct?

A. Yes.

Q. And you understand, don't you, that in Pennsylvania for an adult who makes that incorrect choice, in a non-emergency situation, the only alternative would be a judicial hearing, while if it was a juvenile, the commitment could be made without a judicial hearing?

A. Yes.

Q. Now, Dr. Sugar, you testified that when some social control agency—you mentioned the family or the police or the school, does something to help a child with

some problems that the child may be having, that the kid very often feels a relief; is that right?

(81) A. Yes.

Q. Would you include the Court within those social agencies?

A. It may at times, yes.

Q. Now, let me give you a situation and ask your opinion on it.

Where a child is accused of doing certain things or exhibiting certain bizarre behavior, and the child has a chance to have a lawyer representing him or her, or the child has a chance to give the child's side of the story, and where an independent person, a judge, who the child hasn't met before and has no previous involvement in the case is the one to decide, don't you think that in a situation where the child is not agreed to treatment that the child will feel treated more fairly and have more of a sense of the justice of the situation than in the alternative of the situation where a parent and a doctor get together?

A. Not necessarily, no.

Q. Will you explain.

A. You are dealing with a hypothetical situation, and we don't know what the dynamics are. We don't know what led into the behavior used as a basis for the diagnosis and for admission.

We are talking generally about a point of representing someone's interest and not getting treatment. We are not talking about the need for treatment, the basis for the diagnosis, the basis for a medical opinion being rendered, so just because a lawyer or a judge then say you're really needing (82) admission after the judicial hearing, that doesn't mean that the youngster really is going to be more pleased about it than he was before. Some youngsters are

quite antagonistic to any authority. Some youngsters might be quite manipulative. They will do anything to avoid something that looks onto them as disfavor.

Just because the judge says it, that doesn't mean it will be agreeable or acceptable.

As we know, many of the involuntary admissions for adults, even though they have been adjudicated, the adults still object, still raise holy hell. They still want to get out.

That doesn't mean because the judge says it that a guy is going to be pleased about it.

Q. All right.

But in a situation where an adult has been committed by a Court and objects, the adult has the right to appeal in that situation?

A. We are talking about his accepting it.

I am pointing out that he may not accept it any more because a judge has said so than because his parent or because the doctor has said so.

Q. Do you think for the adults that there is not in general more of an acceptance in a situation where the law would allow commitment for any judicial hearing whatsoever?

A. I don't think there is any way I can answer that question. (83) I would say there is no way to make any kind of statement about that.

MR. FERLEGER: No further questions.

MR. ROTH: I have a few on redirect.

BY MR. ROTH:

Q. Doctor, in order to clarify what I consider to be misleading statements made by opposing counsel in connection with your examination, first of all, with regard to

the purpose of the lawsuit, you have been advised of the two sections that are in question, the voluntary commitment sections which address both juveniles and adults; is that not correct?

A. Yes.

Q. And have you not been advised that plaintiffs are seeking either to have juveniles treated similarly to adults in that juveniles will be allowed to admit or release themselves like adults, or, secondly, in the alternative, if that could not be afforded, that a juvenile would be given a judicial proceeding prior to commitment wherein an attorney would be representing the juvenile and explaining the condition of the juvenile to, if you will, question the validity of the psychiatric evaluation made by other psychiatrists and ultimately determining whether or not the child should be institutionalized? Is that not your understanding?

A. Yes.

Q. Okay.

(84) Now with regard to the procedure in Pennsylvania and the additional regulations, and I'm sure you have read the regulations, have you not?

A. Yes.

Q. Just in looking at the additional regulations which is Annex A, I don't think we need to introduce this as an exhibit. However, it is the additional regulation adopted by the Department of Public Welfare on September 1, 1973.

Could you just read that first paragraph on how juveniles are referred.

A. "All juveniles of aged 18 and younger, to be admitted to institutions must be referred from a recognized medical facility, mental health, mental retardation thera-

pist or mental health agency. However, mentally retarded juveniles may be referred by either a pediatrician or general physician or a psychologist."

Q. Doctor, in terms of a juvenile coming to the doorstep of an institution, it is not as if a parent brings a juvenile and says "Look, I want my child committed or admitted." However, he has to undergo numerous safeguards; is that not correct?

A. Yes.

Q. And then under the Act itself, which you are familiar with in terms of Section 402 and 403, it states, which I would request you to read, and we are referring to Section 402 of the Mental Health and Mental Retardation Act of 1966—would you read that, please.

(85) A. "When an application is made, the Director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted."

Q. So, then we do have an additional psychiatric evaluation being done of the patient.

Now, according to your understanding, would you feel that those are appropriate safeguards?

A. Yes.

Q. Now, there has been—

MR. FERLEGER: I just want to note for the record that there is no indication in the regulations that the referring examination cannot be one and the same as the examination that is made under Section 402 (b).

MR. ROTH: Well, the only way you can get to the institution is by the referral or recognized medical facility.